

## Great Ormond Street Hospital for Children NHS Foundation Trust

# Great Ormond Street Hospital for Children NHS Foundation Trust

### Quality Report

Great Ormond Street Hospital  
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May 2015  
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

### Ratings

#### Overall rating for this hospital

Good



Medical care

Outstanding



Surgery

Requires improvement



Critical care

Good



Neonatal services

Good



Transitional services

Good



End of life care

Outstanding



# Summary of findings

Outpatients and diagnostic imaging

**Requires improvement**



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust operates from a single site in central London. It is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. Children are also treated from overseas in their International and Private Patients' (IPP) wing. There are more than 50 different clinical specialties at Great Ormond Street Hospital (GOSH). Together with the UCL Institute of Child Health, it forms the UK's only academic biomedical research centre specialising in paediatrics. Its status as a Specialist Children's Hospital means that most of the children treated are referred from other hospitals or overseas.

We carried out this inspection as part of our comprehensive acute hospital inspection programme adapted for dedicated children's hospitals. The trust was rated as low risk in the CQC intelligent monitoring system. The inspection took place between 14 and 17 April and unannounced inspections took place between 1 and 3 May 2015. We also inspected the Children and Adolescent Mental Health Services (CAMHS) provided by this trust as part of our inspection.

Overall this trust was rated as Good. We rated it outstanding for being effective and caring. We rated it good in providing safe care. We rated it requires improvement for being responsive to patients needs and in being well-led.

We rated medical care and end of life care as outstanding. We rated critical care, child and adolescent mental health services and transitional services as good. We rated surgery, and outpatients and diagnostic imaging as requires improvement.

Since our inspection, the trust alerted us to long-standing problems with the reliability of their patient information systems, which affected the validity of the trust's reporting of referral to treatment (RTT) times. This had the potential to delay the admission of patients waiting for non-emergency treatment. We have reflected these problems in our assessment of services in this report.

Our key findings were as follows:

- All staff working at the hospital were extremely dedicated, caring and proud to work for the hospital.
- We saw high levels of care, professionalism and innovative treatment of patients who had been referred for care by other hospitals.
- The culture was very open and transparent. Parents and children were kept fully involved in their treatment. There was an evident commitment to continually improve the quality of care provided. Children and young people were involved in decision making as far as possible.
- We saw good examples of duty of candour in practice. Staff were very open when things had gone wrong, expressed full apology and offered full support to parents, children and carers.
- The new Chief Executive was very visible, had shared his vision for the trust and had gained the early respect of staff members.
- The executive team were well known to members of staff and patients and did regular walkabouts on the wards.
- There was outstanding care demonstrated in all departments where there was a tangible level of staff working together in pursuit of excellence of care. All supported the mission statement of the trust which was "the child first and always".
- When decisions were made to stop treatment, this was done thoroughly and with good governance via the ethics committee and always with maximum consultation with parents or carers.
- The reporting of incidents was fully embraced by all members of staff we spoke with. Incidents were thoroughly investigated and learning obtained and shared with all staff across the hospital.
- End of life care was embedded in all clinical areas of the hospital and not seen as the sole responsibility of the palliative care team.

# Summary of findings

- Where the trust had completed a refurbishment or rebuild, the facilities were modern, extremely child friendly and conducive to excellent patient care and dignity. There remained some wards, not yet refurbished, rebuilt or relocated where the environment was less good. The hospital recognised this and was in the middle of a total refurbishment/rebuild project.

We saw several areas of outstanding practice including:

- Clinicians from other hospital services delivered specialist training on physical health issues for CAMHS staff. In return CAMHS staff provided training and expertise to other departments across the hospital, for example on learning disabilities and autism.
- Because the hospital is treating many patients that could be treated at very few hospitals in the UK it is developing ground breaking clinical guidance which it is sharing with clinical colleagues in the wider medical community.
- The hospital has developed a pocket-sized guide to help staff working with children with learning disabilities.
- The Feeding and Eating Disorders Service (FEDS) received 100 % approval in the latest Friends and Family test with 93% saying they were extremely likely and 7% saying they were likely to recommend the service.
- The Psychological Medicine team provided an outreach service across the country where necessary.
- Staff in CAMHS were actively involved in research in their specialist areas including Autism and Feeding and Eating disorders.
- CAMHS introduced a screening tool for mental health problems and the psychological medicine team conducted a study to improve the understanding of the patient experience, diagnosis, treatment and outcomes regarding non-epileptic seizures in children.
- The FEDS and MCU (Mildred Creak Unit) teams developed a policy around re-feeding syndrome to increase understanding of the issue.
- In critical care there were excellent mortality and morbidity meetings, and robust safety monitoring of all patients.
- The Intensive Care Outreach Network (ICON) and Clinical Site Practitioners (CSP) are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours a day, seven days per week.
- In pharmacy services the chief executive receives monthly reports of prescribing errors; a daily check ensures all electronic prescriptions are screened before the end of each weekday (Monday to Friday) and patients are informed by text message when prescriptions are ready.
- In transitional care young people feel empowered by the Young Persons' Forum.
- Joint transitional care clinics are held with on-going hospital providers.
- In outpatients weekly education sessions were protected to ensure staff maintained currency in mandatory areas and had the opportunity to take part in further specialist training from a clinical educator

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

Importantly the hospital must:

- Resume WHO checklist audits in surgery
- Ensure that there are clear arrangements for reporting transitional care service performance to the board.
- Ensure that its referral to treatment (RTT) data and processes are robust and ensure that staff comply with the trust's patient access policy in all cases.
- Ensure greater uptake of mandatory training relevant to each division to reach the trust's own target of 95% of staff completing their mandatory training.
- Ensure that, particularly in critical care, communication between senior nurses and senior medical staff is enhanced and that the contribution of nursing is fully reflected in the hospital's vision.

In addition the hospital should:

- Ensure early improvements in the environments of wards which have not been refurbished, rebuilt or relocated.

# Summary of findings

- Standardise radiation protection training for junior radiologists to overcome inconsistencies caused by short rotations.
- Develop a dedicated advocacy service for its Child and Adolescent Mental Health service ( CAMHS).

**Professor Sir Mike Richards**

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Medical care

Outstanding



### Why have we given this rating?

Patients in medical care services were protected from abuse and avoidable harm. There were enough trained and experienced doctors, nurses and other staff to react if patients deteriorated.

The service was treating many patients that could only be treated at very few other hospitals if any. Multi-disciplinary teams were well coordinated to ensure the best outcomes for patients.

The patients we spoke with were all very positive about the care they had received. One patient told us, “It’s better than being in school, I come in three times a week. I love dancing with the staff”. Another patient told us, “I have to come in for a check up every two years. It’s a very good service, the doctors are brilliant and they’re good at listening and explaining things”.

Medical care services at the hospital were very responsive to the needs of patients. We found many examples where staff had made a special effort to meet the needs of patients.

The trust’s core vision of “The child first and always” was well recognised and owned by staff. The newer version of “always welcoming, always helpful, always expert and always one team” was less well recognised. Staff were focused on delivering high levels of care to patients.

### Surgery

Requires improvement



Incidents were appropriately reported, investigated and learnt from. Staff demonstrated good knowledge of safeguarding procedures and gave excellent examples of recognising and reporting abuse. Theatres and ward areas were visibly clean and hygiene checks were taking place. Patient risks were being appropriately identified and acted upon. Five steps to safer surgery checklists were being completed using a laminated wipe clean sheet but observational audits had not occurred since March 2014.

Care and treatment was being reviewed to show that best practice was being achieved through a trust wide forum that included surgical activity. Clinical audit projects were taking place throughout the surgical specialties. Clinical educators were in place

# Summary of findings

throughout theatres and surgical wards to ensure staff were competent and followed best practice. There was good multi-disciplinary team working throughout the surgical wards of the hospital and we found good examples where staff had worked with issues of capacity and consent.

We found many examples to demonstrate that the hospital was delivering compassionate care. Parent feedback unanimously supported this. Parents told us they had a good understanding of the care their child was receiving and felt the hospital involved them in the care their children received.

There was a backlog of patients waiting more than 18 weeks for surgery, with cardiac, orthopaedics and plastic surgery under the greatest pressure.

Initiatives were in place to work to reduce these numbers. Surgical intake had been staggered to four times a day to reduce waiting times for parents and children.

There were a number of measures in place to meet the needs of patients and families but the quality of some building facilities was variable. For example there were drainage problems and toilets on some wards were not at low level and child friendly. Other wards located in newer parts of the building had better environments and there was a plan to relocate all surgery wards to a new building currently under construction, thus remedying existing premises issues.

Systems and initiatives were in place that ensured patients' individual needs were being met. Meeting the needs of children with a learning disability had been a specific focus of the service and other special needs were also being met.

There were clear visions and strategic priorities, and clear lines of leadership and accountability. We found an open and transparent culture with motivated and compassionate staff.

However we were concerned in relation to the impact on surgical patients following the discovery of unreliable referral to treatment data and inconsistent application of the trust patient access policy.

## Critical care

Good



There were systems and process in place to promote safe and effective care. There was a formal escalation process in place for managing

# Summary of findings

deteriorating children and young people. Incidents were reported, investigated and learning took place. Nurse staffing levels were in line with national guidance. Staff had access to a range of training and professional development, ensuring they were competent for their role.

Policies and guidelines were based on NICE and other relevant national guidelines. The service participated in local and national audit including PICANET. The unit's capacity and flow was managed effectively. There was a vision for the development of the service and identified nursing and medical leadership

## Neonatal services

Good



The NICU at GOSH had very good systems and processes in place to protect babies from harm and these included reporting and learning from incidents. Nurse staffing levels were in line with national guidance and staff had access to a range of training both internally via the GOSH education department and at local universities. The needs of the babies and their mothers or carers were met by skilled and experienced staff including breast-feeding experts. The staff members were accustomed to caring for babies with co-morbidities. Policies were based on NICE and other relevant national guidelines. NICU shares data with the British Association of Perinatal Medicine. There was a formal escalation process in place for managing deteriorating babies and outwith NICU in the high dependency unit care staff have been trained in its use and knew how to effectively use the clinical site practitioner service and the hospital at night team.

The capacity and flow of babies through the NICU was managed by collaborative working with other providers across London and further afield. The team of senior medical team co-ordinated the Intensive Care Outreach Network (ICON) which worked closely with the site practitioner team. Nursing staff felt supported by the senior nursing team and were able to raise concerns without fear of retribution. The staff members we spoke with were fully aware of the new chief executive and his plans for the future direction of the Trust. Interprofessional working was fully embedded within NICU.



# Summary of findings

## Transitional services

Good



Young people were being treated with dignity, respect and compassion. Clinical teams supporting care were committed to supporting young people requiring transitional services. We found examples of excellent care pathways for young people with specific long-term health needs transitioning to adult services.

We saw evidence of trust wide “Transition to Adult Health Services Integrated Care Pathway” (ICP) audit and re-audit of “transition arrangements for young people”. However, we found that there was no overall responsibility or leadership for transitional services in the trust at board level.

## End of life care

Outstanding



Parents we spoke with could not praise the quality of the care and support given by GOSH any higher. One parent wrote in an email, “GOSH and the healthcare professionals involved in our child’s care are leading the world in paediatric care.” All staff across the hospital were found to be compassionate, caring and considerate and wanted to do the best they could for children and their families.

We found that care and treatment was safe, evidenced based and followed accepted standards and professional guidance. There were clear care pathways for children being cared for in the hospital and community and all parties involved in the child’s care were included in these plans.

There was excellent multidisciplinary team working in palliative and end of life care services which included chaplaincy and dedicated psychological and social support teams. An ethics committee safeguarded C&YP interests in the event of a conflict in care and treatment.

Children and their families were given the choice as to whether they wished to receive end of life care at the hospital, at home or in a hospice. The service took into account individual circumstances and needs and supported them in their decisions without judgement.

End of life and palliative care was well-led. The team were thought of highly by colleagues within the hospital and by other professionals from around the world.

The team were passionate about continually improving the service, which included training programmes for nurses and GPs from hospitals

# Summary of findings

## Outpatients and diagnostic imaging

### Requires improvement



There was a culture of high quality, child centred care delivered by competent staff. Effective systems were in place for reporting, investigating incidents using learning to change practice. The environment and clinical equipment were visibly clean and appropriately maintained. Medical records were available but they were not always transported using equipment that was suitably maintained. There was participation in audits and care and treatment was provided in line with professional guidance. Staff had access to a range of mandatory training and professional development. While not all services operated seven days a week, services were flexible to meet patients' needs. There was evidence of multidisciplinary team working and systems were in place to coordinate care with other departments in the trust.

Children, young people and their parents received compassionate care and were encouraged to be involved in decisions about their treatment. Feedback was proactively sought to improve the service. Cancellations were minimal and appropriate action taken. The trust was working to remedy the underlying issues which caused delays in clinics. Informal and formal complaints were listened to and action taken to resolve the issue.

There was a vision and strategy for the development of the service. There was identified leadership who were supportive and motivated staff. Governance and risk management processes were embedded into practice and fit for purpose.

However we were concerned in relation to the impact on outpatients following the discovery of unreliable referral to treatment data and inconsistent application of the trust patient access policy.

# Great Ormond Street Hospital for Children NHS Foundation Trust

## Detailed findings

### Services we looked at

Medical care; Surgery; Critical care; Neonatal care; Child and adolescent mental health services; Transitional services; End of life care; and Outpatients and diagnostic imaging.

# Detailed findings

## Contents

### Detailed findings from this inspection

	Page
Background to Great Ormond Street Hospital for Children NHS Foundation Trust	12
Our inspection team	12
How we carried out this inspection	13
Facts and data about Great Ormond Street Hospital for Children NHS Foundation Trust	13
Our ratings for this hospital	14
Action we have told the provider to take	118

## Background to Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust operates from a single site in central London. It is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. Children are also treated from overseas in their International and Private Patients' (IPP) wing. There are more than 50 different clinical specialties at Great Ormond Street Hospital (GOSH). Together with the UCL Institute of Child Health, it forms the UK's only academic biomedical research centre specialising in paediatrics. Its status as a Specialist Children's Hospital means that most of the children treated are referred from other hospitals or overseas.

The trust is located in the London Borough of Camden, which is ranked 74th of 326 local authorities in the English Indices of Deprivation 2010 (where 1st is most deprived and 326th least deprived). The majority of the trust's services are commissioned by specialist commissioners at NHS England. The trust also has services commissioned by other Clinical Commissioning Groups (CCGs) located in Barnet, Newham, Enfield, Haringey and Ealing in addition to referrals from further afield and abroad.

Great Ormond Street Hospital has been a foundation trust since 1 March 2012. The trust employs around 3975 staff, including 568 medical staff and 1445 nursing staff.

The trust is currently half way through a five phase redevelopment programme to rebuild two thirds of the hospital site over a twenty year period. One new clinical building in this phase opened in 2012 and another will open in 2017.

We carried out this inspection as part of our comprehensive acute hospital inspection programme adapted for dedicated children's hospitals. The trust was rated as low risk in the CQC intelligent monitoring system. The inspection took place between 14 and 17 April and unannounced inspections took place between 1 and 3 May 2015. We also inspected the Children and Adolescent Mental Health Services (CAMHS) provided by this trust as part of our inspection.

We inspected the trust as part of our scheduled comprehensive inspection programme.

## Our inspection team

Our inspection was led by:

Chair: Peter Blythin, director of nursing NHS TDA

Head of Hospital Inspection, Robert Throw, Care Quality Commission

# Detailed findings

The team included CQC inspection managers and inspectors, and a variety of independent NHS specialists as follows: consultant cardiologist, paediatric pharmacist, consultant renal medicine, consultant nurse children's medicine, oncology nurse, general paediatric surgeon, paediatric anaesthetist, cardiac nurse, theatre nurse children's surgery, paediatric intensivist, paediatric critical care nurse, neo-natal nurse, general manager outpatients, specialist rehabilitation nurse, physiotherapist, dietitian,

medical records specialist, palliative care consultant, consultant nurse specialist, palliative care nurse, adolescent nurse specialist, consultant psychiatrist (CAMHS), consultant paediatrician, play specialist, student nurse paediatrics, NHS chief executive/chief operating officer. Also part of the team were experts by experience who represent the interests of patients or their carers.

## How we carried out this inspection

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

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

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included

local Clinical Commissioning groups, NHS England, Monitor, Health Education England, the General Medical Council, the Nursing and Midwifery Council, Royal Colleges and local Healthwatch.

We held one listening event on 25 March 2015 with the intention of listening to the views of children and young people and their families and carers about the services they received.

We talked with children and young people, their parents and carers and members of staff from all the ward areas and diagnostic and outpatient services. We reviewed their records of personal care and treatment.

We carried out unannounced inspection visits between 1 and 3 May 2015 when we followed up in areas where we required further evidence.

## Facts and data about Great Ormond Street Hospital for Children NHS Foundation Trust

### Activity

- Inpatient admissions: 42,732 (2013-2014)
- Outpatient attendances: 213,671 (2013-2014)
- Deaths in hospital: 78 (Apr/14-Dec/14)

### Bed occupancy

- Average (mean) bed occupancy: 94.5% (October 2014 to September 2015)

### Incidents

- Number of never events reported in the period February 2014 to March 2015: Two

- Details of the never events: First: Surgical Error; Second: Retained swab
- Number of serious incidents requiring investigation: 26 - time period this relates to: February 2014 to January 2015
- Details of the type and location of serious incident: Other 14, grade 3 pressure ulcer 2, Medical equipment failure 2, Hospital equipment failure 1, Surgical error 1, remaining 6.

### CQC Inspection History

# Detailed findings

- Number of recent inspections: Four (two of the four inspections were joint inspection of Safeguarding and looked after children services with Ofsted at local London boroughs)

- Date of most recent inspection and results: 25 September 2012 – Published 4 January 2013







Compliance actions: None

## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Outstanding	Outstanding	Good	Good	Outstanding
Surgery	Good	Good	Outstanding	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Outstanding	Good	Requires improvement	Good
Neonatal services	Good	Good	Outstanding	Good	Good	Good
Transitional services	Good	Good	Outstanding	Good	Requires improvement	Good
End of life care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	N/A	Outstanding	Requires improvement	Requires improvement	Requires improvement
Overall	Good	Outstanding	Outstanding	Requires improvement	Requires improvement	Good

# Medical care

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

## Information about the service

Great Ormond Street Hospital provides a number of medical services for children including endocrinology, rheumatology, dermatology, renal medicine, haematology, gastroenterology, cardiology neurology, and oncology.

We inspected both in-patient and day case medical wards including; the dialysis day unit, the respiratory sleep unit, and Fox, Elephant, Giraffe, Lion, Safari, Robin, Kingfisher, Rainforest, Butterfly, Eagle, Starfish, Badger and Penguin wards.

Most medical patients are looked after by one of the following hospital departments namely: Medicine, Diagnostics & Therapeutic Services (MDTS), Neurosciences and Infection, Cancer, Immunity and Laboratory Medicine(ICI-LM).

There were approximately 25,000 medical admissions to the hospital between July 2013 and June 2014. 70% of these admissions were day cases.

We spoke with 23 patients, 29 family members, 37 staff members including clinical leads, service managers and lead nurses, ward staff, therapists, junior doctors and consultants other non-clinical staff. We observed interactions between patients, family and staff; considered the environment and looked at medical records and attended handovers. We reviewed other documentation from stakeholders and performance information from and about the trust.

## Summary of findings

Patients in medical care services were protected from abuse and avoidable harm. There were enough trained and experienced doctors, nurses and other staff to react if patients deteriorated.

This hospital was treating many patients that could only be treated at very few other hospitals if any. The hospital was very effective at coordinating its multi-disciplinary teams to ensure the best outcomes for patients.

The hospital performed well in the NHS Friends and Family Test (FFT) to the core question “How likely are you to recommend our ward to friends and family if they needed similar care or treatment?” 99.2% of respondents stated they were likely or very likely to recommend the hospital.

The patients we spoke with were all very positive about the care they had received. One patient told us, “It’s better than being in school, I come in three times a week. I love dancing with the staff”. Another patient told us, “I have to come in for a check up every two years. It’s a very good service, the doctors are brilliant and they’re good at listening and explaining things”.

Medical care services at the hospital were very responsive to the needs of patients. We found many examples medical services staff had made a special effort to meet the needs of patients.

The trust’s core vision of “The child first and always” was well recognised and owned by staff throughout the

# Medical care

trust. The newer version of “always welcoming, always helpful, always expert and always one team” was less well recognised. Staff were focused on delivering high levels of care to patients.

## Are medical care services safe?

Good



We rated medical care services good for safety.

The service had a robust process for ensuring that clinical incidents were reported, investigated and learning from them was fully shared with all staff.

Staff kept patients safe at all times and they were aware of the correct action to take should safeguarding issues arise. There were varying levels of compliance with mandatory training.

Enough doctors and nurses were on duty at all times to make sure that patients were kept safe. There were processes in place to make sure unwell patients were monitored and given medical support if they deteriorate.

### Incidents

- There had been no never events in medical services between April 2013 and March 2014. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
- Between April 2013 and March 2014 medical services reported 6 serious incidents through the National Reporting and Learning System (NRLS). Of these incidents, one concerned an equipment failure. There was no trend or pattern in the other five serious incidents.
- Staff we spoke with stated they were encouraged to report incidents. They knew how to report an incident and said they reported incidents frequently. Nursing staff told us they received feedback on the incidents they had reported. For example, we examined a recent renal incident report for March/April 2015 which clearly set out a summary of all reported incidents and the detailed investigation and outcomes.
- One manager told us about an incident that had occurred in which a total parenteral nutrition (TPN) infusion had emptied much more quickly than expected. The incident had been immediately reported and a rapid investigation had identified an equipment



# Medical care

fault. This fault was immediately communicated around the trust and other faulty items of equipment were detected. As a result of the rapid and effective process no other patients were exposed to harm.

- Other staff we spoke with were all aware of the TPN incident, and were able to explain how they had changed their behaviours as a result. A senior nurse explained that, if a drugs error occurred, there would normally be a discussion with the nurse. If a second error occurred within 12 months, the nurse concerned would have their practice supervised. A third error would usually lead to suspension of the nurse's rights to dispense drugs.
- We found that duty of candour principles were being followed. Staff were able to give examples of where things had gone wrong and how patients and families had been immediately informed and provided with support, for example where a child had been given the wrong dose of chemotherapy.

## Safety thermometer

- Staff used the term nursing quality indicators rather than safety thermometer. All the wards we visited were recording and monitoring key safety risks such as; central line infections, hand hygiene audits and infection outbreaks.
- We found that safety thermometer information was displayed in an inconsistent way on different ward notice boards. Some wards had no information, or information that was difficult to interpret, whereas some wards had good information for patients, visitors and staff to look at.

## Cleanliness, infection control and hygiene

- All the wards we visited were visibly clean with cleaning schedules clearly displayed on the wards. There was a lack of clarity about the cleaning of toys and which toys were suitable for clinical areas. The hospital lead for infection control confirmed that a new policy was to be issued shortly to clarify the situation.
- Hand hygiene gel was available at the entrance to every ward and along corridors. There was clear signage at these locations directing people to wash their hands using the gel dispensers.
- Hand hygiene audits were carried out monthly with the results usually being placed on the ward notice board. We found compliance rates of between 80% and 100%.

- Some nursing staff told us that, on occasions, it could take up to two hours for the cleaning staff to attend the ward to clean cubicles for the next patient.
- Staff followed the trust infection control policy. We observed that staff regularly washed their hands in between seeing patients, and they used personal protective equipment (PPE) such as gloves and aprons when needed. We saw that staff complied with the trust's 'bare below the elbows' policy.
- The trust's infection rates were monitored through an infection control dashboard. Rates for central venous line (CVL) infections, hand hygiene compliance, and CVL bundle usage were monitored.

## Environment and equipment

- Equipment was maintained and records demonstrated that checks were carried out regularly to ensure it continued to be safe to use. The equipment was clearly labelled stating the date when the next service was due.
- We examined the resuscitation equipment on each ward. There had been daily checks of resuscitation equipment which had been documented. All staff we spoke with immediately knew where the resuscitation trolley was located and were able to lead us to it. Staff were able to describe what each of the items of equipment on the trolley were to be used for.
- The hydrotherapy pool was suitable for its purpose. We found that there were resuscitation trolleys in all physiotherapy areas.
- Some staff we spoke with told us that the estates department was often slow in making repairs once they had been reported.

## Medicines

- Medication was almost always stored securely. Rooms where medicines were stored were almost always locked. However, we found two open and unattended drug cabinets on Lion ward during our inspection.
- Controlled drugs (CDs) were checked by two nurses either once daily or at each shift change. There were independent checks by pharmacy when a new CD register was started and at three monthly intervals. Wards had individual CD stock lists and orders for any other CDs had to be approved by the ward pharmacist or validated against Electronic Prescribing (EP) records. Daily CD checks were verified by inspection of the CD registers.

# Medical care

- The hospital had 24 hour/7 day per week clinical pharmacy support. Outside normal pharmacy opening hours this was provided by an on call pharmacist who was resident overnight in the hospital in case they were needed. This meant that there was always a paediatric trained pharmacist to respond to queries and supply medications. During the week (Monday to Friday), all wards had pharmacist cover; some from sub-specialist pharmacists, and all wards were visited daily (M-F). Haematology and oncology wards had additional pharmacist cover at the time of our inspection because of an on going project looking at pharmacist support for prescribing and medicine use.
- The pharmacy department had aseptic preparation facilities which operated under a “special” licence. All medicines, including those for named patients, were prepared under this licence. Operating as a licensed unit means the hospital facilities had to meet the same standards as commercial suppliers. Some deficiencies were found in the last licence regulatory inspection (November and December 2013) and the facilities were placed in “special measures”. They were now out of special measures following remedial action taken by a newly appointed quality assurance pharmacist.
- On some wards doctors had a dedicated quiet area for prescribing undisturbed. This minimised any distractions during the prescribing process. We observed this area and were also told about this practice by a senior staff nurse. Doctors (including consultants) were also challenged if they tried to prescribe whilst still on the clinical ward round.

## Records

- Records were kept in paper format and all health care professionals documented their notes in the same record. Patients’ records were appropriately completed and were legible with entry dates, times and designation of the person documenting indicated. We found that many of the patients’ notes had loose sheets in them which created a risk of important information being lost or being incorporated into the wrong notes.
- We examined a number of notes on each ward we visited. We found that in most cases nutritional assessment charts had been completed; pain assessment tools were complete, safeguarding information was present and comprehensive, and consent forms had been completed.

- Patient information and records were stored securely on all wards. We found that in the day clinics notes were not always available for clinical staff. Staff we spoke with told us that on average 80% of full sets of notes were available in day clinics. We also found that it could take up to three to five days for notes to be returned to the medical records department following a clinic. The trust told us that the turnaround time on clinic letters was five days.

## Safeguarding

- There was a safeguarding policy and procedure in place and staff were aware of these and where they could get further advice and support if needed.
- 95% of nursing staff and 93% of doctors were trained to level three (the highest level) for safeguarding. However, play specialist staff were only trained to level two despite having the same level of close contact with patients.
- Staff were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns. Staff we spoke with were able to give examples of when they had used the trust’s safeguarding policy to raise concerns. For example they described a case where they had ensured a father who had a history of violence towards a child’s mother was still able to see his very sick child but under proper supervision.
- Volunteers we spoke with described how robust their vetting process had been with personal information being checked and references verified in all cases. This included disclosure and barring service (DBS) checks on all staff.
- The hospital receives a large number of visits from high profile celebrities. The hospital had a clear policy for ensuring that patients remain safe at all times and visitors are always supervised. Staff we spoke with were aware of this policy and confirmed that no one was ever allowed unsupervised access to patients.

## Mandatory training

- Mandatory training covered a range of topics including fire safety, consent, emergency paediatric life support, child safeguarding, manual handling, and equality and human rights. Most staff we spoke with told us they were up to date with their mandatory training.
- However, data provided by the trust showed that there were in some areas poor levels of training compliance

# Medical care

recorded on the hospitals database. For mandatory training the trust set a target of 95% compliance. We found that actual training percentages of staff trained ranged from best to worst as follows; Resuscitation Level 2 Adults (100%), Introduction to Information Governance initial training (95%), Safeguarding Children Level 1(96%) and Safeguarding Children Level 3 (95%) of 30 training courses reached this level. The worst compliance rates were; Resuscitation Level 3 (41%), Infection Prevention and Control Level 2 (40%), Blood Transfusion Paediatric Level 1 online learning (33%), and Blood Transfusion Paediatric Level 2 online learning (14%).

- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs. All new staff we spoke with said they had completed the induction training.

## Assessing and responding to patient risk

- The hospital used a children's early warning score (CEWS) system to monitor patients' conditions. Nurses took key vital signs such as respiration, temperature and blood pressure for each patient at regular periods. These were entered onto a hand held tablet which then calculated an overall risk score for the patient. The system was not a replacement for clinical practice but was designed to prompt nursing staff to consider if they needed additional nursing or medical support.
- The hand held CEWS tablets were linked to other staff which meant that if a high risk was identified an alert was automatically sent to the ward manager and clinical site practitioner team.
- Staff we spoke with said they were well supported by doctors when dealing with deteriorating patients.
- The clinical site practitioner team consisted of senior nurses who were able to provide support to nursing staff caring for very sick children. The members of the clinical site practitioner teams we spoke with knew exactly where the very ill patients were and had plans in place to provide extra support if needed.
- The hospital used a situation, background, assessment, recommendation and decision (SBARD) system to communicate information about patients who were unwell.
- The clinical site practitioner team allocated roles to key staff in the case of a cardiac or respiratory failure anywhere in the hospital. During our unannounced visit

to the hospital at night, we found that these roles had been allocated and clearly recorded. Staff we spoke with from the team were clear about their specific responsibilities in the case of an emergency.

- During our inspection of Starfish Day Care Unit, we observed that there were very small treatment rooms which would have made it difficult to manoeuvre a hoist or a resuscitation trolley in the case of an emergency.
- All potentially allergic children were seen by a dietician to ensure that any nutritional risks were minimised.

## Nursing staffing

- Nursing staffing levels had been reviewed and assessed using the Paediatric Acuity Nurse Dependency Assessment (PANDA) tool. Managers told us that generally the medical wards worked to a ratio of two patients for each nurse.
- There were 343 nurses in post compared to an establishment of 341 nurses.
- Staff felt that senior managers would listen to their concerns about staffing levels. Manager told us that when there were nursing shortages on the roster these would usually be made up from bank staff who already worked in the hospital. Occasionally, external agency staff would be used.
- There were higher numbers of nurses in high areas of need, such as the respiratory ward. One patient we spoke with told us, "There is always a nurse around, they are always checking to see that we are alright".
- The trust had a low sickness absence rate of 2.6%
- Nursing staff we spoke with told us that they felt there were enough nurses to keep patients safe. One nurse told us "There are enough nurse here, if we ever go short we usually find a replacement but we can cope anyway". A ward manager told us "If we know we are going to be short a few days ahead then we can usually reduce the number of beds".

## Medical staffing

- There were enough doctors to fill the medical roster and ensure that patients were kept safe all of the time.
- The services had 243 medical doctors (consultants, middle and junior grade doctors) to cover 400 in-patient beds. 43.9% of doctors were consultants compared to an NHS average for England of 32.6%. The hospital had a large registrar group making up 56.1% of doctors

# Medical care

compared to an NHS average of 39.5%. There were fewer junior doctors which meant that patients were looked after by more experienced doctors than in most NHS hospitals.

- Doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and out of hours and that consultants were contactable by phone if they needed any support.
- We observed the medical handover in the morning and at night with the 'hospital at night team'. The process was led by the general paediatrician. The hospital at night team medical cover consisted as a minimum of: an intensive care outreach network registrar, three registrars each covering Medical, Neurology/Respiratory and Haematology/Oncology; two anaesthetists, a cardiology registrar and a surgical registrar. All the staff we spoke with felt that this provided enough medical capacity to keep patients safe at night.

## Major incident awareness and training

- Emergency plans and evacuation procedures were in place. However, many of the staff we spoke with had not had recent training in fire safety and other major incidents.
- Staff we spoke with were aware of major incidents plans and how patients would be evacuated from the hospital in an emergency.

## Are medical care services effective?

Outstanding



We rated the effectiveness of care provided by medical care services outstanding.

This hospital was effectively treating many patients that could only be treated at very few other hospitals in the UK. Because of this, the hospital often developed its own clinical guidance which it shared with clinical colleagues in the wider medical community. Robust and regular clinical audit was firmly established within the culture and processes of the medical department. Where one area was found to be deficient the trust commissioned an independent review and acted immediately on its early findings and recommendations.

The hospital was very effective at coordinating its multi-disciplinary teams to ensure the best outcomes for patients. The hospital had a wealth of experienced allied health care professionals who were often available to provide care on a 24/7 basis.

Trusts should use the Gillick competency to help them assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. We found that staff had a good understanding of Gillick and Fraser child rights and consent guidelines and that these guidelines were being appropriately followed. Consent and capacity issues were properly recorded in patients' notes including Mental Capacity Act assessments for those aged 16 and over.

## Evidence-based care and treatment

- Medical services adhered to National Institute for Health and Clinical Excellence (NICE) guidelines for the treatment of patients. The trust had an effective process of monitoring the implementation of NICE guidance. For example, we found evidence that the trust was following the NHS pathway for biologic therapies for the treatment of Juvenile Idiopathic Arthritis.
- All potential national audits had been assessed for relevance by the trust clinical audit manager to clarify which audits covered the services provided by the hospital.
- The trust had completed a large number of audits in 2014 in areas such as Cardiac Arrhythmia, Congenital Heart Disease, Renal Replacement therapy and Severe Trauma. Many of the staff we spoke with had participated in these audits or were aware of them and how this had changed practice at the hospital. Records we examined indicated that the hospital had reviewed every available case in each of the clinical audit areas with a compliance rate of 100% for all audits in 2014.
- We saw that the medical department was participating in a large number of clinical audits, including Cardiac Rhythm Management, Diabetes (Paediatric), Inflammatory Bowel Disease programme; Maternal, New born and Infant Clinical Outcome Review Programme, National Cardiac Arrest Audit, National Comparative Audit of Blood Transfusion programme, Renal replacement therapy, Pulmonary Hypertension Audit. We found that the hospital had reviewed all potential national audits and had documented valid reasons why

# Medical care

there were participating and how much progress had been made. The hospital provided us with documentary evidence showing action taken to improve patient care as a result of these audits.

- Medical services had good results in the national Paediatric Diabetes Audit (2012/13) compared to England & Wales average. Scoring 73% compared to a 16% England average for patients below the Glycated Haemoglobin NICE target.
- Up to date NICE and trust guidelines were available on the trust intranet. Staff we spoke with told us that guidance was easy to access, comprehensive and clear. Nurses and Doctors were able to find guidance easily on the intranet when we asked them.
- Because of the nature of patients at the hospital there were many examples where there was no existing clinical guidance. The trust had often written its own guidance which it usually made available to other hospitals and clinical colleagues on its intranet site. We found that all of the guidelines had been reviewed in 2014.
- Dietitians we spoke with at the hospital were fully aware of British Association of Dietetics guidelines and were following them.
- The hospital was effective at providing patients who were unable to digest food themselves with total parenteral nutrition (TPN). At the time of our inspection 40 patients were on TPN.
- We found that every year around two hundred research projects were started at the hospital. At any one time there were about five hundred research projects taking place. The work was often undertaken in conjunction with the University College London Institute of Child Health (ICH).

## Pain relief

- The hospital had a pain service available for patients 24/7. This was staffed by a small team of nurses and a doctor in the day and an anaesthetist at night. The pain team were proactive in visiting all children in the hospital who may be at risk of suffering pain. We saw the pain team working on a number of wards during our inspection. Staff told us that they came to most wards everyday to see if any patients needed support with their pain.

- We observed staff monitoring the pain levels of patients and recording the information. Pain scores were recorded in most of the patients' notes we examined.
- Parents and carers we spoke with told us that the hospital was very good at helping patients to reduce pain. One parent told us, "They really try to make sure that he isn't in pain; they are always checking to see if it hurts and giving him something to help if he needs it".

## Nutrition and hydration

- Approximately half of all patients in the hospital were on special feeding regimes, for example, TPN or special feeds. This included 20 children who received special diets.
- We found that each ward had a folder produced by the hospital dietetic team to assist nursing staff. The folder provided information and guidance on dietetic issues and feeding regimes.
- Every patient who had been in the hospital for more than two hours was given nutritional screening to ensure any key risks were identified and a suitable nutritional regime was implemented to support that patient.
- We examined audit records from April 2015 which recorded an 86% compliance rate with the screening tool.

## Patient outcomes

- We observed the clinical practice of a number of play therapists which was following guidelines of good practice. Staff told us that the play therapists were effective and they were available when needed. For example, if a child needed to be distracted from a difficult procedure, such as taking a blood sample.
- We found that hospital psychologists were linked to wards and were able to provide support to staff, families and patients. Patients were often transferred to the hospital because other hospitals did not have the capability to provide patients with effective care.
- Many of the clinical services provided outcome data to national or international registries. These registries monitor incidence of disease, clinical management of conditions and treatment outcomes. The medical department had used this information to compare and challenge performance for example in areas such as HIV, Nephrology and the treatment of Cystic Fibrosis.



# Medical care

- Doctors were often staying beyond their rostered shift to ensure that their patients were safe and had the best treatment.
- Staff told us and the trust was aware that the gastroenterology medical team were disorganised and care plans for patients were inconsistent, with changes being made based on which doctor was on duty with no consistent treatment pathways for patients.
- To address this issue the trust commissioned an independent review of the gastroenterology service and immediately took action upon receipt of early findings of the review. Actions included a review of all gastroenterology referrals by MDT chaired by the Medical Director; revised approval process of procedure lists; revised case review, diagnostic and treatment guidelines and complex case review and management at MDT at which compulsory attendance was required.

## Competent staff

- Newly qualified nurses underwent a 6 - 12 months preceptorship. This meant that although they did count towards the ward staffing numbers, they were in a protected environment which supported their training and development.
- Health Care Assistants (HCAs) had an initial induction period of training and practice covering basic care, washing, feeding, and resuscitation. HCAs were clear about their role and were not asked to undertake inappropriate duties for which they were not qualified or trained. We found that some HCAs had received further development, for example in tracheostomy care.
- Staff we spoke with told us that the trust's initial staff induction programme was detailed and comprehensive. For example the consent training had an input from a lawyer and the heads of security and safeguarding also had significant inputs.
- Clinical staff we spoke with told us they had regular annual appraisals. Staff were also supervised clinically and felt that handovers, ward rounds and board rounds provided them with regular learning opportunities.
- Data provided by the trust to the NHS showed that the appraisal rate for staff was in line with the England average.
- Trainee doctors we spoke with said they were well supported and the hospital was a safe place to work. Teaching was supported and changes to guidelines

were cascaded through email, meetings and newsletters. Some junior doctors said that when the hospital was very busy they were not always able to attend training sessions.

- The nursing handovers, which we observed were effective. They included a discussion of each patient and their progress and any potential concerns.

## Multidisciplinary working

- Throughout our inspection, we saw evidence of multidisciplinary team working in the ward areas. Clinical staff told us nurses and doctors worked well together within the medical speciality.
- Psychologists, physiotherapists, occupational therapists, pharmacists, dieticians, play therapists and social workers we spoke with all told us that multi agency working was generally effective. Some nurses told us that they did not always feel that all safeguarding information was passed onto them by their social work colleagues.
- Occupational therapists (OTs) we spoke with told us that they felt part of the clinical team and were treated with respect by doctors and nurses. The manager of occupational therapy told us that there were currently 17 out of 19 OT posts filled. The recent freeze on recruitment within the Medicine Diagnostic and Therapeutic division had meant two posts were not currently being filled.
- Staff we spoke with told us that members of the gastroenterology team were slow at attending their outlying patients who were on other wards.
- Staff we spoke with told us that patients who needed to undergo interventional radiology were often subjected to long waits with lists regularly overrunning and some patients not undergoing the procedure at all, although they had been on 'nil by mouth' from the previous night.
- Managers told us that concerns about delays in interventional radiology was on the medical services risk register. They told us that there was a plan to make the process more effective and a junior doctor had already been employed to speed up the 'clerking' (initial medical assessment) process.
- We spoke to a number of physiotherapists who told us that they felt a full part of the team caring for the patient. They said that patients were appropriately referred to them by other professionals.

# Medical care

- We found that hospital psychologists were linked to wards and were able to provide support to staff, families and patients.

## Seven-day services

- There was a consultant presence on all the medical wards seven days a week. Staff we spoke with told us consultants were on call out of hours and were accessible when required.
- Dieticians were available during the week and from 9am- 1pm at weekends.
- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday. There were resident pharmacists on call at the hospital out of hours if needed.
- The radiography department was open seven days a week but with limited hours on Saturday and Sunday. There was a resident radiographer on call at the hospital out of hours if needed.
- Play therapists were available five days a week and there was no cover at weekends.
- The physiotherapy department was open seven days a week. There was a resident physiotherapist on call at the hospital out of hours if needed.

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

- The trust had an up to date and comprehensive consent policy issued in October 2014. There were also comprehensive consent forms for patients under 16 and separate forms for those aged 16 and 17 and for those aged 18 and older.
- We found that consent to treatment for patients was obtained following correct procedures. Families and carers were involved in discussions about consent.
- Staff were able to describe the correct process for establishing the consent of patients. We found that staff were aware of and able to describe how consent issues changed as children became older and were more able to make their own choices.
- We found that staff had a good understanding of Gillick and Fraser guidelines and that these guidelines were being appropriately followed. Consent and capacity issues were often discussed at MDT meetings to ensure a rounded view was reached.

## Are medical care services caring?

Outstanding



We rated the care provided by medical care services outstanding.

The hospital performed well in the latest NHS Friends and Family Test (FFT) to the core question “How likely are you to recommend our ward to friends and family if they needed similar care or treatment?” 99.2% of respondents stated they were likely or very likely to recommend the hospital.

The patients we spoke with were all very positive about the care they had received.

Patients and families received a high level of emotional support from nursing staff at ward level. In addition, the hospital social work team and chaplaincy service were proactive in finding people in need of additional support.

## Compassionate care

- In the Friends and Family Test results published in December 2014 response rate was 30.47% (262 responses out of 860 patients) compared to a national average of 30%.
- To the core FFT question “How likely are you to recommend our ward to friends and family if they needed similar care or treatment?”, the trust performed very well with 99.2% of respondents saying they were likely or very likely to recommend the hospital.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. The patients and families we spoke with were generally very pleased with the care provided. They told us doctors, nurses and other staff were caring, compassionate, and responded quickly to their needs.
- The patients we spoke with were all very positive about the care they had received. One patient told us, “It’s better than being in school, I come in three times a week. I love dancing with the staff”. Another patient told us, “I have to come in for a check up every two years, it’s a very good service, the doctors are brilliant and they’re good at listening and explaining things”.

# Medical care

- One parent told us, “It’s 10 out of 10 as far as I am concerned, it’s great”. Another parent said, “It’s the place we want to be at the moment, we feel safe here”.
- We observed a large number of interactions between staff and patients and their families. We observed that staff were open, friendly and approachable but always remained professional. We observed that patients and families were often delighted when they saw staff they knew and greeted them as if they were old family friends.
- To help patients with the process of coming into the hospital pre-admission visits can be arranged. This allows the patients to see the hospital and their ward before they are actually admitted.
- When children have completed a course of chemotherapy in the oncology unit, they are encouraged to ring a large bell to celebrate that they have finished their treatment.
- In some cases, patients are sent a ‘picture story’ that sets out in pictures, with a few words, the journey they will take from home into the hospital.
- We found many examples where staff had provided additional support for patients and families for example, ordering take away food, arranging car parking passes. Staff always work with families to ensure that patients’ birthdays are celebrated.

## Patient understanding and involvement

- Patients and families we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant and to ask as many questions as they wanted. One parent told us, “they always explain everything, sometimes I bring up things I have found on the internet and they take the time to explain if that would work for us”.
- Patients and families we spoke with told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns about the way they had been spoken to. All were very complimentary about the way in which they had been treated.

- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their families about the care and treatment options.

## Emotional support

- All families were contacted by a hospital social worker soon after they arrived at the hospital to see what financial or emotional support could be provided. This can include arranging accommodation near to the hospital, psychological counselling or referral to specific support groups.
- The ‘chaplaincy service’ covered a range of faiths including Anglican, Catholic, Free Church, Jewish and Muslim and was available to provide patients and their families with emotional support. Representatives of other faiths could be contacted as required.
- We found that the ‘chaplaincy service’ was proactive and would visit patients and their families on the wards to see if there was any support they could provide.

## Are medical care services responsive?

Good



We rated the responsiveness of medical care services to the needs of patients as good.

With the exception of Rainforest ward, the medical service at the hospital was very responsive to the needs of patients. We found many examples where the hospital and its staff had made a special effort to meet the needs of patients.

The trust performed in line with the England average in the Patient-led Assessments of the Care Environment (PLACE). The trust showed improvements between the 2013 and 2014 assessments in all four categories of: cleanliness, food, privacy dignity and well being and facilities.

The Learning Disabilities Champion implemented a learning process called ‘Better Care – Healthier Lives’. This involved four principles of; engaging people with learning disabilities and their families, enabling the spreading of information and initiatives through link staff, showing compassion and knowing every life had worth and making cultural change and implementing innovation.



# Medical care

## Service planning and delivery to meet the needs of local people

- Staff we spoke with were very aware of the different needs of their diverse patient group. Staff were able to describe how different needs were met by the trust for example, learning disabilities, babies, teenagers and physically disabled patients. For instance, we found that a hot meal was regularly arranged at 7pm for a child with Cystic Fibrosis and they were also given a daily 'snack bag'.
- The trust had performed in line with the England average in the Patient-led Assessments of the Care Environment (PLACE). The trust showed improvements between the 2013 and 2014 assessments in all four categories of: cleanliness, food, privacy dignity and well being and facilities. The largest improvement was in food where the 2014 score was 87 compared to 61 in 2013.
- We found that the environment of Rainforest ward was cramped and needed to be improved. Some patients were accommodated in bays of four beds which have a very small floor area. There was no privacy even when curtains were drawn. Some parents told us that the patients' beds were too small. On Rainforest ward there are no en suite rooms and there were only two toilets on the ward. The ward had up to eight patients with gastroenterology conditions. On some occasions, patients with infections or who had undergone nuclear medicine diagnosis tests, needed to have one of the toilets allocated to themselves, which left only one of the toilets for the rest of the patients on the ward.
- Staff told us that the gastroenterology medical team were disorganised and care plans for patients were inconsistent, with changes being made based on which doctor was on duty with no consistent treatment pathways for patients. Senior managers in the hospital we spoke with confirmed that the physical environment and resulting patient experience on Rainforest ward was recorded on their risk register and an independent review had been commissioned.
- We found that in day clinics there was no process for separating patients of different ages. We observed that teenagers were waiting next to young babies and toddlers. Most in-patient wards we observed had separate areas for adolescent patients.

## Access and flow

- The hospital does not have an Accident and Emergency Department. Most patients were transferred from district general hospitals (DGHs) following discussions between the consultant at the DGH and the appropriate consultant at the hospital. The hospital had clear guidelines for which patients are appropriate to be admitted.
- There are about 25,000 medical admissions each year. 88% of these are from consultants at other hospitals. 10% are referred by GPs and 2% come by other routes.
- The hospital had 'flagged' 459 of its patients as living with learning disabilities in the 12 months before our inspection. The hospital has a learning disability consultant nurse who is the lead for providing training, advice and support to other staff in the hospital. To support them, they had given enhanced training to 37 link learning disability staff.
- There was a trust wide operational group who were responsible for the co-ordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new patients to be admitted into. Bed meetings were held at 9.30am and 4pm each day. They also discussed any action that was required when wards were at full capacity.
- There was a bed management system that ensured managers had a clear picture of where the demands and spare beds were in the hospital at any given time. This meant that in the case of space being needed in an emergency the hospital was able to respond quickly and effectively.
- The trust had three levels of alert for the bed status, Green (beds are available), Amber (there are a limited number of beds), and Red (no beds are available). In addition, there was a Blue status when there were no available beds in intensive care. During our inspection the hospital was on Amber status.
- During our inspection we observed that there was flow into, out of the hospital and within all the wards and every ward had some capacity to take new patients.

## Meeting people's individual needs

- Patient nutrition assessments were undertaken on a regular basis. The results of the surveys were used to improve services.

# Medical care

- The patients and families we spoke with told us they were always given choices of food and snacks. Patients were positive about the quantity and quality of the food they received in the hospital.
- The trust had installed a wi-fi service (with suitable content controls) that allowed patients and their families to connect their laptops and other mobile devices to the internet. This enabled patients to keep in touch with their friends outside of the hospital.
- Wards were provided with modern gaming consoles to ensure that patients were able to play these games if they wish.
- Information was available in English and Arabic as a matter of routine. Information in other languages could be provided on request. The international and private wing of the hospital had a dedicated Arabic interpreter 12 hours a day seven days a week. The Arabic Patient Liaison Manager was also available to other parts of the hospital if needed.
- The hospital provided 'passports' for patients living with learning disabilities, which allowed them to identify to staff important information about themselves and their likes and dislikes in a pictorial format.
- The hospital provided home haemodialysis. This meant that patients were able to spend more of their lives at home with their families.

## Learning from complaints and concerns

- Staff told us that they did their best to deal with issues and complaints at a ward level. In the first instance the ward manager would speak to the patient and their family.
- We found that the Patient Advisory and Liaison Service (PALS) was proactive in dealing with patients' concerns. PALS staff would attend wards to see if any patients or their families had any concerns about the service they had received.
- The Learning Disabilities Champion had implemented a learning process called 'Better care – Healthier Lives'. This involved four principles of; engaging people with learning disabilities and their families, enabling the spreading of information and initiatives through link staff, showing compassion and knowing every life had worth and making cultural change and implementing innovation.

Good



We found leadership in medical care services to be good.

The trust's core vision of "The child first and always" was well recognised and owned by staff throughout the service. The newer version of "always welcoming, always helpful, always expert and always one team" is less well recognised. Staff were focused on delivering high levels of care to the patients they cared for.

The hospital had systems in place for ensuring effective clinical governance. We observed that there was a clear focus on reducing clinical risk and improving patient outcomes.

The hospital holds annual learning disabilities awards to acknowledge good work by staff. The awards ceremony was chaired by a person with learning disabilities. Awards were made for; empowering people, creative communication, making reasonable adjustments and innovative practice.

## Vision and strategy for this service

- The trust's core vision of "The child first and always" was well recognised and owned by staff throughout the service. The newer version of "always welcoming, always helpful, always expert and always one team" was less well recognised by staff we spoke with. This had been launched in the month previous to our inspection.
- The visions for the trust for 2014-19 are: to have the best patient outcomes and experience; to be an exemplar employee and excellent educator; to be a world-leading paediatric research institution; to be partner of choice for referrers, and to be a financially and environmentally sustainable organisation.
- Many staff we spoke with were not aware of the recent freeze on recruiting new staff and how it specifically applied to their areas of operation. Staff were not aware of how this fitted into the overall financial strategy of the trust.

## Governance, risk management and quality measurement

## Are medical care services well-led?

# Medical care

- If a Serious Incident was reported, a named executive would hold an initial meeting at 8.30am on the following Monday to review the initial investigation and take appropriate initial action.
- The whole trust had a monthly Learning Implementation and Monitoring Board (LIMB) to review incidents. This was linked to departmental quality and safety meetings attended by ward managers.
- Each clinical department held a monthly board meeting attended by appropriate representation including the divisional director, service manager, and speciality leads. The board looked at risk, finance and key performance indicators on the 'Dashboard'. Ward boards were then held to disseminate information at ward level. We observed that there was a good focus on clinical risk and performance.
- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The doctors' handovers we observed were thorough and well structured with patient risks covered through a flagging process.
- Medical services had a risk register which was where risks were documented and a record of the action being taken to reduce the level of risk was maintained. For example, risks about ward environment had been identified.
- Medical services had an annual plan for 2014-15/16 setting out how it would improve in the following areas: patient experience, quality, safety and risk, finance/operational efficiency, workforce and research and innovation.

## Leadership of service

- Ward staff felt well supported by their ward sisters and lead nurses and told us they could raise concerns with them. Staff told us that they regularly saw managers and clinical leads on the wards. The director of nursing, chief operating officer and chief executive were visible to staff on the wards.
- Some senior nurses we spoke with told us they did not always feel part of the senior management structure. We observed that although medical leads attended the hospital senior management team meetings, their equivalent nursing leads did not.

- We found a number of examples where consultants were staying late into the night to look after patients and give guidance and support to junior colleagues.
- We were particularly impressed by the consistently high level of leadership we found in the ward managers we observed during our inspection.
- We spoke with a number of medical services managers who had a good understanding of the issues in their clinical areas. For example, managers had identified that there was a need to improve the interventional radiology service and an action plan had been implemented.
- Junior and middle grade doctors felt well supported by their consultants and other senior colleagues. Medical staff felt supported by the medical leadership in the department and the trust.
- We observed good leadership skills during medical and nursing handovers. Senior staff were visible in leading these meetings and giving clear direction and support to junior colleagues. For example, during a medical handover, we observed an acute paediatric consultant give direction to a specialist registrar to undertake a number of clinical investigations to help in diagnosing a patient.

## Culture within the service

- Throughout our inspection there was a distinct child and young person centred culture within the hospital. Staff we spoke with at all levels were focused on obtaining the best outcomes for the patients in their care.
- There was a strong team spirit from top to bottom with staff as diverse as consultants, cleaners, radiographers and nurses being very clear that they were all there for the patients.
- Staff spoke very positively about the high quality care and services they provided for patients and were proud to work for the hospital. They described the hospital as a good place to work and having an open culture. The most consistent comment we received was that the trust was a good place to work and people enjoyed working there.

## Public and staff engagement

- Patients were engaged through feedback from the NHS Friends and Family test and complaints and concerns raised from PALS. Clinical governance meetings showed patient experience data was reviewed and monitored.







# Medical care

- Staff engagement around the trusts future strategy had not always occurred. There is a great deal of building work going on in and around the hospital and this will continue for many years. Staff told us that they did not know what the plans were for the trust in the future and in particular, when and if their wards would be moved to other areas.
- Sickness absence rates were around 2.5 days per year and consistently below the England average.
- The learning disabilities champion implemented a learning process called 'Better care – Healthier Lives'. This involved four principles of; engaging people with learning disabilities and their families, enabling the spreading of information and initiative through link staff, showing compassion and knowing every life had worth and making cultural change and implementing innovation.
- 'Safety huddles' took place throughout the day in the private patients wing. During these huddles, staff worked together to identify critical safety issues in fast time and implement rapid solutions. Staff we spoke with told us they thought this created a safer environment for patients.

## **Innovation, improvement and sustainability**

- Innovation was encouraged from all staff members. Staff said that new ideas and analysis of the way things were being done was positively encouraged by managers.
- The hospital used hand held tablets to record CEWS scores on wards. These were electronically connected to ward managers and the site practitioner team.

# Surgery

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

## Information about the service

The hospital provided a range of paediatric day case, elective and emergency surgical services to a national population of children, including urology, orthopaedic, plastic surgery, ear, nose and throat, cardiac, neurosurgery and general surgery. 47% of cases were day case procedures, 51% were elective and 2% were emergency cases. In the 12 months prior to the inspection 12,590 operations had been carried out.

There were 11 theatres plus one currently being refurbished. There were three interventional radiology theatres. Theatres ran for nine hours a day, five days a week. On Saturday there were private lists and occasional NHS lists. Availability for emergency lists was 7 days a week.

There were 56 inpatient surgical beds in the designated surgical wards and 12 patients could be accommodated on the surgery day case ward. Cardiac and neurosurgery patients were accommodated separately.

We visited 12 wards and areas. This included all wards where surgical patients were accommodated, the anaesthetic pre-assessment clinic, day care and gastro investigation. We visited the theatres and the recovery area. We spoke with 25 patients and families, observed care and treatment and looked at 28 care records. We also spoke with 35 staff members, including allied healthcare professionals, nurses, doctors, consultants, ward managers, and senior staff. In addition, we reviewed surgical performance information about the trust.

## Summary of findings

Incidents were appropriately reported, investigated and learnt from. Staff demonstrated good knowledge of safeguarding procedures and gave excellent examples of recognising and reporting abuse. Theatres and ward areas were clean and hygiene checks were taking place. Patient risks were being appropriately identified and acted upon. Safer surgery checklists were being completed using a laminated wipe clean sheet but observational audits had not occurred since March 2014.

Care and treatment was being reviewed to show that best practice was being achieved through a trust wide forum that included surgical activity. Clinical audit projects were taking place throughout the surgical specialties. Clinical educators were in place throughout theatres and surgical wards to ensure staff were competent and followed best practice. There was good multi-disciplinary team working throughout the surgical wards of the hospital and we found good examples where staff had worked with issues of capacity and consent.

We found many examples to demonstrate that the hospital was delivering compassionate care. Parent feedback unanimously supported this. Parents told us they had a good understanding of the care their child was receiving and felt the hospital involved them in the care their children received.

# Surgery

There was a backlog of patients waiting more than 18 weeks for surgery, with urology, cardiac, orthopaedics and plastic surgery under the greatest pressure. Initiatives were in place to work to reduce these numbers. Surgical intake had been staggered to four times a day to reduce waiting times for parents and children.

Concerns were raised following a review of referral to treatment (RTT) systems affecting surgery patients. The review indicated both unreliability of data and inconsistent application of the trust's patient access policy.

There were a number of measures in place to meet the needs of patients and families but the quality of some building facilities was variable. For example there were drainage problems and toilets on some wards were not at low level and child friendly. Other wards located in newer parts of the building had better environments and there was a plan to relocate all surgery wards to a new building currently under construction, thus remedying existing premises issues.

Systems and initiatives were in place that ensured patients' individual needs were being met. Meeting the needs of children with a learning disability had been a specific focus of the service and other special needs were also being met.

There were clear visions and strategic priorities, and clear lines of leadership and accountability. We found an open and transparent culture with motivated and compassionate staff.

## Are surgery services safe?

Good



We rated safety in surgery services as good.

Incidents were appropriately reported, investigated and learnt from. This was aided by risk action groups (RAG) which met locally and the learning, implementation and monitoring board (LIMB) which reviewed serious incidents. Staff demonstrated good knowledge of safeguarding procedures and gave excellent examples of recognising and reporting abuse. Theatres and ward areas were clean and hygiene checks were taking place. Equipment was also clean and serviced. Patient risks were appropriately identified and acted upon. This included effective use of the risk register and children's early warning scores.

Safer surgery checklists were being completed using a laminated wipe clean sheet which contained adequate information in terms of what needed checking. Observational audits had been carried out to ensure this process was being completed but had not occurred since March 2014.

Electronic prescribing had been introduced in theatres over the previous year which had led to a reduction in drug errors and a better audit trail in terms of who had prescribed and who had given medication.

### Incidents

- Surgery accounted for 57% of the hospital's reported serious incidents (SIs). There were currently four open SIs in the process of being investigated. The head of nursing for surgery (HNS) provided detail regarding the process of investigation and reporting which was aligned to a timeline in order to ensure timely reporting and learning. We were given some examples of recent incidents and how they had been investigated and learnt from.
- There had been one never event in the last year. This had been learnt from and staff we spoke with were knowledgeable about the incident, its investigation and how practice in theatres had been improved as a result.
- Key learning from incidents was raised in morning meetings in theatres and wards. The HNS met with ward



# Surgery

sisters to talk about 'live issues' on the wards and within the hospital as well as to spread learning from incidents which she expected sisters to in turn share with ward staff.

- Surgical leads had completed their Duty of Candour training. The HNS told us that the culture of the organisation, especially with the new chief executive (CEO), was about valuing openness. The number of days since the last serious incident was published on the trust website.
- A lead cardiothoracic surgeon told us multidisciplinary meetings were held fortnightly within their department and open discussion was encouraged. Incidents were discussed in this meeting where lessons learned were communicated. We observed a cardiothoracic multidisciplinary meeting. A consultant told us they encouraged a no blame culture and encouraged all staff to give open and honest feedback. Serious incidents were discussed in this meeting along with lessons learnt and change to practice.
- The learning, implementation and monitoring board (LIMB) reviewed serious incidents. Minutes from February to April 2015 demonstrated that incidents were discussed and a learning and action focus was taken at this meeting. LIMB information leaflets were sent to all staff regarding practice improvement and learning from SIs. This was also presented at senior meetings, available on the trust intranet and read out to theatre and ward staff in morning meetings.
- On Sky ward we found a copy of the LIMB information sheet on display in the staff room. This was also shared in monthly staff meetings. Ward teams we spoke with were aware of the surgical risk manager and how to report an incident. Staff felt supported to report incidents when things go wrong and felt the trust was open and transparent.
- In theatres, every first Wednesday of the month a 'risk action group' (RAG) took place. The group included a consultant anaesthetist, consultant surgeon, clinical educator and senior operating department practitioner (ODP). All incident reports were reviewed. Learning from incidents was relayed to staff in the daily morning handover meeting, at the dedicated weekly teaching slot and through email to all staff. For example, the RAG identified an issue with the consent forms used and changed this with the assistance of the trust solicitor and consultants.

- If a never event occurred, a meeting would be convened within 48 hours to discuss how care could be changed to prevent its recurrence. Care practice had been changed in relation to a recent never event (retained swab) within the previous four weeks. This included extra surgical counts after surgery finished and prior to the patient leaving theatre. A policy was also being implemented on accountable items.
- We were shown the trust intranet by a practice educator. Learning from incidents was easy to access. All staff had access to all of the trust's root cause analyses and SI reports, consisting of a full report and bullet points for learning. Also in the quality improvement section there was a 'dashboard of the week'. During our inspection the subject was theatre overruns. Also available through the intranet was the LIMB flyer, which was also emailed out to all trust staff with details of incidents, learning and changes to practice.
- On Squirrel ward staff were knowledgeable about reporting incidents through the on line reporting process and were able to tell us about learning from a recent incident including implementation of a new protocol. A weekly general surgery team meeting took place to discuss planning and give feedback on incidents.

## Safety thermometer

- Practice educators collected safety thermometer data which was collated and results sent out for the whole trust. Data was collected on early warning scores (EWS), moisture lesions, pressure ulcers, pain and extravasation (leakage of intravenous fluid/drugs). Results were presented at the nursing board for surgery where variances and action that needed to be taken in relation to these were agreed.
- The HNS told us that the safety thermometer results on EWS were quite varied because they did not take blood pressure as part of the score. Instead, 'nerve centre' was an on line monitoring tool which monitored blood pressure. We were also told that surgery were looking to manage their own tissue viability practice. Nurses were being trained to manage skin integrity themselves, as opposed to relying on the hospital's tissue viability nurse to assist. This initiative included a re-launch of the tissue viability link nurse system.

# Surgery

- On Koala ward, the neuro science unit, safety thermometer results were on display along with nursing performance indicators. We were told these were under review as there was considerable overlap between the two.
- On Sky ward we found limited ward display of safety thermometer information. Some surgical data was displayed high up on the wall and in small print, thus difficult to read. On Sky and Bumblebee wards we found the ward 'dashboard' that displayed hand hygiene and central venous line (CVL) data only. This was on A4 sized paper. It did not explain any action that might have been taken in relation to poor results or explain what any of the graphs meant, so it was difficult for visitors, or staff, to understand its meaning. Staff we spoke with were vague about ward performance and felt it was only about hand hygiene. There was no awareness of improvements or action taken with regard to this performance.

## Mandatory training

- Mandatory training included safeguarding, information governance, resuscitation levels 1 and 2, equality, diversity and human rights, fire safety, infection control and moving and handling. Training numbers showed a variance in levels of attendance. For instance, theatre, ward, pre-operative assessment, urodynamic and pain teams all showing high attendance rates. However others had not consistently reached the target of 95%.
- Part of the practice educator's role was to monitor the training database and ensure line managers kept their staff up to date with mandatory training.
- On Sky ward we found an electronic flagging system to notify staff who were not up to date with their mandatory training. Local records showed staff were 88-90% up to date with training.
- On the neuroscience unit we were told that most training was face to face but also supplemented by e-learning.

## Safeguarding

- All clinical staff were trained to safeguarding children level 3 standard. All non-clinical staff had received level 1 training.
- Staff we spoke with on a variety of wards and theatres were able to tell us about child protection, how to report issues and about safeguarding procedures.

- On Koala ward, the neuroscience unit, staff were knowledgeable about what constituted abuse and gave us excellent examples of when they had suspected abuse in a variety of different forms such as over sedation, physical chastisement and children suddenly having complex needs. Ward staff were supported in child protection work, decision making and contact with families by a social worker.
- There was a safeguarding flowchart on display on some wards that identified what action to take when abuse was suspected.
- When we asked theatre staff about visiting surgeons to the theatre unit, they were not able to tell us what the process was needed to be complete prior to them being fit to practice.

## Cleanliness, infection control and hygiene

- There were six divisions within the trust, three of which had surgical activity. Each held local infection control divisional meetings on a regular basis. Compliance with care bundles and audit results were discussed at these meetings as were any action plans and their progress/ completion.
- A trust wide infection prevention and control highlight report was produced on a monthly basis, containing information on infection rates for specific organisms such as MRSA and e-coli. This was reported to the divisional infection control meetings. For general surgery these were alternate bi monthly meetings which focussed on either surgical or theatres. Minutes demonstrated that hand washing audits were reported. They showed compliance with good practice such as MRSA screening, recording intravenous (IV) lines, and central venous line (CVL) care bundles compliance. Results were discussed with actions to be taken by a named person.
- During 2014/2015 there had been 10 reported spinal wound infections or events of delayed healing. Work had been carried out to support improvement in standardisation of care for patients undergoing spinal surgery. Information had been extrapolated from root cause analyses and an action plan produced with detailed planned improvements, individual responsibilities and an identified review date.
- The infection control audit plan identified which areas should conduct which audits, and specified their frequency. For example, hand hygiene should be



# Surgery

monthly for all wards and all departments and a minimum of twenty observations should be completed each time. The central venous line (CVL) care bundle for insertion should take place monthly in theatres with a minimum of ten observations each time. There had been three CVL infections on wards in the last 2 months.

- The infection control audit showed a number of items audited on a monthly basis. This included hand hygiene, central venous line infection, surgical site infections, central venous line insertion and urinary catheter insertion and infection. The audits were broken down into areas and specialities such as theatres, wards and neurosciences and presented as a dashboard.
- All patients were MRSA swabbed in the anaesthetic pre assessment clinic and the MRSA information leaflet was sent to parents if children were found to be positive.
- Multidisciplinary meetings for surgical specialties discussed all infection rates and data was presented for discussion. We observed the cardiothoracic multidisciplinary meeting where discussion took place.
- Koala ward was a newly built unit which was visibly clean and hygienic. We spoke with one cleaner who had a good rapport with staff and families and was enthusiastic about meeting the hygiene needs of the unit. Hand sanitisers were regularly replenished. There were logs for legionella testing. Screening took place for MRSA and multidrug resistant Gram negative organisms. There was a high standard of hygiene, with single patient use of children's playdough to prevent cross infection.
- Operating theatres were clean and tidy. There was no equipment left in corridors. An infection bay had been identified in the post anaesthetic care unit (PACU), where equipment was suitably cleaned after usage. Gloves, hand sanitising gel and hand wash facilities were readily available and utilised. We observed gloves being removed following each procedure and hand washing was completed.
- Decontamination of instruments and equipment was outsourced to a nearby acute hospital. An incident regarding some instrument packs arriving back on site with holes in the sealed packs had recently been investigated and resolved. Instruments were now supplied in metal containers.
- We observed the urology ward round which was attended by medical staff of different grades. Hand sanitising gel was used as they moved between patients.

## Environment and equipment

- On Koala ward, which was the neuroscience unit, we found a good range of movement and handling equipment. Resuscitation equipment was kept clean and tidy and records showed it had been checked regularly. All equipment was in date with PAT (portable appliance) testing and oxygen cylinders were appropriately secured.
- A consultant told us, in their opinion that equipment in gastro interventional services was ageing and needed replacing. Records showed that the equipment had been serviced and was in date.
- Staff in endoscopy demonstrated the process of traceability of the scope used for each patient. When a scope was used, a blue sticker accompanying the scope, was put in the patient's notes. It contained information on which washer was used, the time and date it was processed and the decontamination process. This meant that if there was any issue with any of the process, it could be traced to individual patients and individual scopes.
- Equipment was available as required in theatres. Gel pads and positional aids were clean, tidy and readily available. Equipment such as fluid pumps had a tracker system and could be traced if they were not in theatre. All equipment we observed was up to date with servicing and had an asset equipment number and barcode for individual identification. Staff told us they felt the medical equipment department was efficient and reliable. Staff felt they were easy to contact and responsive to their needs.
- A separate instrument washer had been purchased to avoid cross contamination. This project was still ongoing.
- Some high priced consumables such as cardiac valves were stored in an 'omnicell' cabinet, which relied on thumb print recognition to access. This meant that items were traceable to individuals when removed. If they were not utilised they could be returned rather than re ordered.
- In theatres, resuscitation trolleys were cleaned and checked daily. This was documented and signed.

## Medicines

- Electronic prescribing had been introduced in theatres over the last year which had led to a reduction

# Surgery

in drug errors. On Koala ward we found that pharmacy was accessed by an 'omnicel' thumb print recognition drug cabinet. Controlled drugs were securely stored and had been regularly checked. Parents were encouraged and supported to administer their child's medications.

- Electronic drug prescribing was utilised in theatre. There was a computer in the anaesthetic room and in theatre on the anaesthetic machine. The consultant anaesthetist highlighted that the feedback for electronic drug prescribing was varied. This was because the system would allow any dosage to be prescribed and for any weight of patient, thus not picking up even the most obvious of drug error. However, it did allow a better audit trail in terms of who had prescribed and who had given it out. This increased accountability in the system.
- On Bear ward (cardiac) we reviewed 10 electronic prescription charts. All had been completed fully with allergy and microbiology advice.
- In theatres, drugs were stored using the drugs Intelligent Storage System. This involved all staff keying in an identity code to gain access to medicines from the cabinet. This enabled a better audit trail of who had accessed it and allowed drugs to be automatically re-ordered as the system could identify which drugs had been taken. Pharmacy staff stocked this up weekly. We observed drugs that had been drawn up prior to the theatre list left unattended in the anaesthetic room along with the drug keys while staff went to attend the team brief in a different room. This was immediately brought to the attention of the nurse in charge.
- On Sky ward the resuscitation trolley was checked daily and was fully equipped when we checked. Pharmacy visited the ward twice a day during the week (Monday to Friday).
- We spoke with a ward pharmacist who told us that medication for patients to take out (TTOs) on discharge, was made up 24 hours in advance in order to prevent delayed discharges.

## Records

- On Puffin ward, an intake unit for both day and inpatient surgery, records were a mix of paper and electronic. Allocation of appointment times would usually occur a week in advance, which was when the records department would be notified for retrieval. Records retrieved by the Puffin ward clerk, were often from a number of locations within the hospital depending on

where each patient may have previously been located. We observed a nurse on duty preparing files for the next day's intake. If records could not be located prior to a child visiting, the consultant was called at 3pm the day before the appointment to decide on whether it was feasible to go ahead with the procedure. We were told that for reasons of complexity of procedures, some operations had to be cancelled at this stage for safety reasons, while others went ahead once the electronic record was confirmed with the anaesthetist. Elsewhere ward clerks we spoke with told us it was their responsibility to retrieve records for the wards.

- Most critically ill patients transferred from other hospitals were retrieved by a retrieval team (CATS) and transferred with their records. If necessary, arrangements were made for direct transfer of patients to surgery, for example, where surgery was time critical.
- On Koala ward, patient progress notes had been routinely updated and were clearly written, dated and signed. Nursing care plans were personalised and routinely updated.
- Koala ward had four dedicated videotelemetry beds (telemetry monitoring is a test that looks at the function of the brain by a series of nerve impulses), for the diagnosis and investigation of children with seizures. The children were monitored by one nurse, except in the case of invasive electrodes where they were cared for on a 1:1 basis.
- We reviewed three sets of patient notes on Sky ward. We found notes were completed and were up to date. This included care plans, fluid charts, pain assessment, skin intact forms, pre-op checklists and consent.
- On Bear ward (cardiac) we reviewed seven sets of notes which were a combination of electronic and paper records. We found patient records to be complete and up to date. Assessments included nutritional, safeguarding, growth and risk assessments. Notes also demonstrated that early warning scores had been completed and that there was multidisciplinary input in to each child's care. Pre assessments were thorough and demonstrated good links to anaesthesia and other specialties. Notes also demonstrated that tests were done and reported on the same day.
- Care plans in theatre were on paper and had been continuously reviewed and updated utilising a multidisciplinary team approach. There was also an electronic system called PIMS. However, staff identified

# Surgery

that this was outdated and slow although when it was demonstrated it appeared easy to use and understandable. However it did not link with other electronic systems. In pre assessment we found a newly installed electronic document management system which was interlinked with other departments to enable good communication of patient progress. This was a pilot.

- We observed the urology ward round which was attended by medical staff of different grades. Clear plans on patient management were agreed and recorded in notes by junior doctor.

## Assessing and responding to risk

- We found CEWS was in use on surgical wards. These were being audited and risks escalated appropriately. All children had risk assessments in place.
- On Koala ward, an escalation policy was in place which used the Paediatric Glasgow Coma Scale (The Paediatric GCS is used to measure conscious level in children). The children's early warning score (CEWS) was also used. Staff we spoke with were knowledgeable about their use and the process of escalation with high scores.
- There was a newsletter available on line for resuscitation service and lessons learned. The Koala ward sister told us that the use of electronic observation recording (nervcentre) and CEWS meant the number of crash calls was reduced.
- The cardiothoracic multi-disciplinary meeting discussed the number of surgical complications at one week, one month and three months since treatment. Nurse practitioners called families in for feedback and progress reports prior to the meeting. A lead cardiothoracic surgeon told us surgical results were also being assessed month on month with the previous year for type of operation and individual surgeon. The variable life-adjusted display (VLAD) was used to show the difference between expected and actual cumulative mortality and surgeons' performance.
- On Bumblebee ward safety huddles took place three times a day and involved all staff. (Safety Huddles are typically short briefings designed to give frontline staff and bedside caregivers' opportunities to stay informed, review events, make and share plans for ensuring well-coordinated patient care.) This was being rolled out across the surgery division.

- If the patient's wrist band was not viewable during surgery when checking blood or blood products for transfusion, then a scanner was used to scan the wrist band and print out patient details on a sticker. This was then stuck on to the consent form.
- Emergency surgery lists commenced daily at 1.30 p.m. Consultants told us they would always fit them in and would come in earlier if needed for these.
- On Sky ward morbidity and mortality (M&M) meetings took place quarterly and were led by a consultant and discussed with the whole team.

## Use of the 'five steps to safer surgery' procedures

- The surgery safety checklist was undertaken by a coordinator using a prompt sheet that sufficiently identified the three phases of an operation; before the induction of anaesthesia ("sign in"), before the incision of the skin ("time out") and before the patient left the operating room ("sign out"). Each stage identified key information to be checked.
- This was carried out using a laminated prompt sheet which was kept on the patient trolley and wiped clean after each patient. A paper record of this did not exist. We were later told by the trust that this information was recorded electronically on the PIMS system. We observed all sections of the checklist being properly undertaken however the laminated sheet was not cleaned prior to being placed on another trolley.
- Observational audits had been carried out to ensure this process was being completed. However, this had not occurred since March 2014. We were later told by the trust that this data was regularly reviewed at performance review meetings.

## Nursing staffing

- Following a recruitment drive two years ago, which had greatly reduced the number of nursing vacancies through recruitment from different parts of the UK, the hospital now found vacancy rates rising again as many nurses were now returning home. The trust had responded by staging recruitment days and attended newly qualified nursing events.
- An analysis of nursing staffing numbers, as at December 2014, showed low vacancy rates within surgery, which averaged at 8.5% but varied from area to area. For instance, the vacancy rate was one post on uroynamics day care but was minus 3 posts on Puffin ward. We were not told why there was this variation.

# Surgery

- On Koala ward, the trust had cut the number of bandsix nurses from 21 to 12, which had resulted in difficulty covering shifts, with staff needing to work overtime to provide senior cover. Following negotiation the level of bandsix cover was increased by six to 18. There were nine qualified staff and one healthcare assistant on each and every shift including weekends. There were two band seven nurses who were in supervisory roles. There were four telemetry beds within Koala ward, the neuroscience unit, which was staffed separately and increased if the acuity rose. Patients were also monitored by neurophysiology staff. One parent told us they appreciated when nurses worked the long day shift because it allowed for better continuity and enabled staff to pick up changes in neurological status more quickly.
- The hospital had its own nursing staff bank called Bank partners. On Sky ward they were able to adequately manage their staffing shortfall through the use of bank staff which was mostly staff from its own ward and other surgery staff.
- We found Walrus ward (heart and respiratory) were carrying vacancies but managed to fill empty shifts through the hospital bank staff system and with mostly surgical staff.
- The duty rota for theatre staff was devised using an electronic system. A shared drive was used to request annual leave and off duty. Theatres did not use agency staff but did use the hospital's own bank staff.
- In theatres, there was a band 7 and band 6 nurse for every surgical speciality. The band 6 rotated each year through the specialities and the band 7 was responsible for their speciality. Band 5 nurses rotated every 3 months. New starters were supernumerary for 9 months and also rotated. The night team was mainly made up of permanent night staff although day staff did rotate through night shifts too.
- Puffin (surgical intake) and Woodpecker (day case) shared a play worker, play specialist, and all nursing staff. Staffing had been monitored and reviewed over the past year which had resulted in more HCAs located to duties on Puffin.
- Throughout our inspection we observed nursing staff in the surgical division including wards and theatres to be professionally dressed in accordance with best infection prevention and control practice.

## Surgical and medical staffing

- Within the surgery division there were two SHOs covering, with support from SHOs and specialist registrars and Fellows until 8pm on weekdays. After 8pm on weekdays there was a surgical registrar or medical registrar on duty from the hospital's rota, supported by a medical registrar from the hospital at night team. At weekends there was a resident surgical registrar and resident medical registrar on call. Also on call was a consultant from an on call rota.
- Surgical consultants also covered their own patients. We found examples of surgical consultants coming in at weekends and doing ward rounds at weekends.
- On Koala ward, the neuroscience unit, there was adequate medical cover with specialist registrars and F2 doctors to cover. Consultant neurologists and neurosurgeons were available on call. Walrus ward (heart and respiratory) had consultant, SHO and registrar cover from 8am to 6 pm on weekdays with plans for junior doctor cover to be extended to 8am to 8pm.
- The anaesthetist clinical lead told us that registrars would not be left to undertake a list or on acute duty by themselves/without support. We spoke with a core medical trainee who told us that the teams in general surgery were fully staffed and they were supported by seniors to carry out their work.
- In gastro interventional services we found there was a core of anaesthetists and medics with no vacancies. However, one consultant told us there were always capacity issues and the service needed more consultants to meet the service's needs.
- A ward sister on Koala ward told us that consultants did ward rounds at weekends. On Squirrel ward nurses said that doctors were easy to contact and attend the ward. This included weekends. A member of the nursing team in theatres told us that consultants for surgery came in at night and weekends when required.
- We observed the urology ward round which was attended by medical staff of different grades. Clear plans on patient management were agreed and recorded.

## Major incident awareness and training

- The HNS attended the committee that addressed business continuity. They told us they had recently been involved in a heatwave planning exercise with a newly appointed incident planning officer.

# Surgery

- Theatre staff told us they would stop sending for patients when there was a major incident in order to free up capacity.
- A staff nurse in theatres demonstrated the ease of accessing policies on the intranet including business continuity in the event of a major incident.

## Are surgery services effective?

Good



We rated the effectiveness of surgery services as good.

Care and treatment was being reviewed to show that best practice was being achieved through a trust wide forum that included surgical activity. Surgery staff were now increasingly producing data and comparisons to other centres, both nationally and internationally; more common procedures were now beginning to be compared with other UK specialist children's hospitals.

Clinical audit projects were taking place throughout the surgical specialties. Clinical educators were in place throughout theatres and surgical wards to ensure staff were competent and followed best practice. This included supporting students and new staff, organising mentorship and preceptorships and maintaining protected teaching times.

Pain was being effectively managed and regularly monitored. Nutrition and hydration was being effectively managed. There was good multidisciplinary team working throughout the surgical departments of the hospital and we found good examples where staff had worked with issues of capacity and consent. On wards, patient files demonstrated that consent was being taken.

### Evidence-based care and treatment

- The learning, implementation and monitoring board (LIMB) was a trust wide forum to which all divisions with surgical activity contributed. The LIMB January 2015 minutes demonstrated that implementation and compliance with NICE guidance was monitored through this forum. This included monitoring newly issued guidance and review by the clinical leads within the hospital. This forum also reviewed best practice through review of audits and quality strategies and CQUINs (quality and innovation initiatives).

- One clinical educator was currently involved in a piece of work about the traceability of neurosurgical instruments with CJD (Creutzfeldt-Jakob Disease) and NICE guidelines. This was in conjunction with an instrument company to trace all instruments and processing. A separate instrument washer had been purchased to avoid cross contamination. This project was still on-going.

### Pain relief

- Pain was being regularly monitored on surgical wards. Assessments had been completed in all patient files we reviewed. Pain charts had been updated regularly.
- Data on pain management was collected and monitored as part of the safety thermometer data. The safety thermometer dashboard information from December 2014 to March 2015 included the 'proportion of patients in pain at the point of survey' and showed a median score of 6% compared with 10% for the hospital as a whole.
- In addition to surgical wards managing patients' pain, the pain team were also available. The pain team in surgery consisted of an anaesthetist and three nurse specialists. They carried out two daily rounds of the wards and monitored intravenous morphine infusions. On Sky ward, we found patient controlled analgesia (PCA) was in use. (PCA is a system that allows pain relief medicine to be given using a programmed syringe pump). Staff were trained in the use of syringe pumps.
- We spoke to one small child and their parent. They told us they had been in pain in recovery and they had been seen by an anaesthetist who listened to them and really helped with the pain management.

### Nutrition and hydration

- We reviewed patient notes on a variety of wards including 3 sets of notes on Sky ward and seven sets of notes on Bear ward. We found fluid charts and nutritional assessments had been completed and were up to date.
- We spoke with one patient and their parent who had come in and was seen in a critical state at short notice. They told us they were seen by a consultant at 2am, were dehydrated and put on intravenous fluids. They told us they were now eating and enjoying the food.



# Surgery

- Snack boxes had been introduced to assist the fasting patient following surgery. Prior to admission children and parents were asked about their preferences for a lunchbox which was then made up individually. Feedback to this initiative was very positive.

## Patient outcomes

- There were a number of clinical audit projects currently registered in surgery and throughout the surgical specialties. For instance, anaesthesia, audiology, dental, orthopaedics and maxillofacial all had audits registered with start and end periods specified. A sample of current audits included post-operative constipation in adolescent idiopathic scoliosis patients, fasting times for elective surgery patients and speech outcomes following segmental maxillary osteotomy.
  - Lead surgeons told us that they were now increasingly producing data and comparisons to other centres, both nationally and internationally. Certain procedures were compared with outcomes internationally when procedures were not carried out anywhere else in the UK, but other, more common procedures were now beginning to be compared with other UK specialist children's hospitals. For instance bladder exstrophy and stoma closure had international comparisons while inguinal hernia repair and ENT procedures had national comparisons. The hospital also contributed to the UK national airways database.
  - Planned re-admission within 30 days was 3.2% although the procedures carried out were of a complex nature, meaning these were often referred by other centres following unsuccessful surgery, or to carry out a procedure that was complex. The emergency re-admission rate within two days of surgery was 2.5% compared with 1.4% for other specialist children's trusts. Mortality rates had reduced to 1.6% from 3.8% three years ago.
  - The extracorporeal membrane oxygenation (ECMO) service, (a technique of providing both cardiac and respiratory support to patients whose heart and lungs are unable to provide an adequate amount of gas exchange to sustain life service), benchmarked its outcomes against international units. There were only 3 ECMO units in the UK.
- and one for wards. Both were headed up by a team leader and comprised of staff who worked 50/50 with their clinical work. In total this amounted to 5.5 whole time equivalent posts dedicated to ensuring staff were competent and followed best practice. The role included supporting students and new staff, organising mentorship and preceptorships and maintaining protected teaching times.
- On Koala ward, induction of new staff included a preceptorship programme, local induction to the unit and being supernumerary. All staff completed a mentor qualification in their first year and attended two post-basic module training modules at a local university. We also found that staff appraisals were all in date.
  - On Sky ward, NMC registration for nursing staff was renewed twelve weeks in advance and all nursing staff were up to date with their registration. Set recruitment was aligned to trust induction. Wards had a six month preceptorship period that involved competency and objective setting. Newly qualified nursing staff started at the same time to share and enhance learning experiences.
  - Staff from different wards and departments told us that there were opportunities for courses and study but as staffing rotas were now tight, it had left little opportunity to take these up. On Sky ward we found that funding was available for band 6s to do degrees and MAs with some protected time to do it, although we did not know how many were able to take this up.
  - Theatre staff had a one hour protected teaching session each week. It moved to different days of the week so that it would not delay the same list each week. This time was also used for individual teams, such as scrub or anaesthetic, to discuss issues that had occurred or needed resolution.
  - One of the practice educators in theatres had been involved in setting up the Children's Hospital Alliance for Real Innovation in Operating Theatres (CHARIOT). This was a partnership forum involving other regional UK centres for paediatric care. They were currently revising the training and competency package for HCAs in theatres. They were also able to share opinion on practice and equipment in order to understand effectiveness as a group.
  - There were volunteers who assisted in theatres with non-clinical matters. The volunteer link nurse and lead nurse for theatres reviewed the volunteers and

## Competent staff

- There were two teams of practice educators in the surgery division. One was predominantly for theatres

# Surgery

discussed any issues that arose with them. A volunteer induction programme was designed prior to using volunteers and included spending a day in theatre for them to get a perspective on the process and patient experience. The volunteer link nurse ensured that all DBS checks and contracts were organised.

- Theatre scrub staff stayed in one surgical specialty for a minimum of six months at a time to gain appropriate knowledge and experience. This was assisted by a competency book for theatres. All new staff were allocated a preceptor and met with a team leader and preceptor at the start of their probationary period and at stages through it, in order to look at what support was needed to enable their development. All new staff, no matter what grade, completed a theatre competency book which was to be completed within the six month probationary period.
- New operating department practitioners (ODPs), who were involved with the overall planning and delivery of a patient's perioperative care, were supernumerary for their first nine weeks.
- We spoke with a core medical trainee who told us the training offered was very good and they felt supported in their work.
- A lead cardiothoracic surgeon told us the system for doctor revalidation was by senior medical staff and other consultants out of the specialty. Appraisals were documented and up to date.

## Multidisciplinary working

- We found good multidisciplinary team (MDT) working throughout the surgical departments of the hospital. There were weekly MDT meetings on wards and daily team briefs.
- On Sky and Bumblebee wards, we found this included multidisciplinary morbidity and mortality meetings, weekly 'grand' ward rounds and daily ward rounds, multidisciplinary safety huddles and weekly ward MDT meetings.
- A lead cardiothoracic surgeon told us they felt the service had good relationships with medical teams, x ray, cardiology and critical care. Multi-disciplinary meetings were held weekly within the department, where all cases were reviewed and open discussion encouraged.

- In pre- assessment we found the IT system was newly installed and well interlinked with other departments and disciplines. There was good access to tests, laboratories and the wards.
- There was a MDT meeting held weekly within theatres. This discussed patients' needs and scheduling of theatre lists that needed repopulating. A theatre scheduler ensured that lists were adequately populated. Theatre staff worked with other members of the MDT. For instance, in spinal, during our visit there was an anaesthetist, surgeon, neuro physiologist, radiologist, theatre staff and porters. All were involved in the team brief.
- The multidisciplinary team brief in theatres was conducted daily although a prompt sheet was not used. If changes to the order of the daily lists were made, then the senior nurse in the theatre changed the list electronically and printed out a new list. Although it did not include the wards with any of these decisions, it did include PACU. Everybody introduced themselves and the process was undertaken methodically.
- Bed meetings were held daily. Staff told us this worked well and felt there was a good supportive multidisciplinary team.

## Seven-day services

- Elective weekend surgical activity was mainly for private patients. Patients went to Sky ward after surgery. Seven lists a month were run on Saturdays. Theatre staff volunteered on a bank basis and we were told it was not a problem to staff this. However, the HNS told us they would like to formalise this arrangement going forward. There was no input from physiotherapy or occupational therapy (OT) to support this service which delayed discharge in some cases where assessments were needed, as they could not be undertaken until Monday.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We found good examples where staff had worked with issues of capacity and consent. On wards patient files demonstrated that consent was being taken.
- The risk assessment group in theatres had identified an issue with the consent forms used and changed this with the assistance of the trust solicitor and consultants. The consent form had been reviewed and revised in February. The current form was concise, signed by the consultant carrying out the surgery, and a parent or a

# Surgery

child if appropriate. When the patient was welcomed in to the anaesthetic room, consent was checked with staff and parents. If the patient's wrist band was not viewable during surgery when checking blood or blood products for transfusion, then a scanner was used to scan the wrist band and print out patient details on a sticker. This was then stuck on to the consent form.

- On Bumblebee ward we found examples where the consultant had taken consent with an interpreter.
- We saw three consent forms on Sky and Bumblebee wards, which included site marking. All were taken by a consultant and were Gillick competence based and individual. We asked what happened if a patient refused when they arrived at theatre. We were told that standard procedure was to stop and return to the ward. Psychology assistance and play specialists were available to assist with further support and identification of related issues. Trust solicitors were accessible to support clinicians with consent queries.
- The HNS told us that the trust solicitor had attended senior management meetings for surgery to discuss capacity and consent. The practice education team did twice yearly ward updates that incorporated consent and the Mental Capacity Act 2005 (MCA).
- In theatres, we observed staff communicating well with children and their relatives. Children and parents understood what their procedure entailed.
- Patients with a learning disability were flagged up on the system which enabled more time to determine whether capacity would be an issue when they came in.
- The Positive Outcome Experience Management Strategies (POEMS) was promoted within the trust. This was a one day course for practitioners that introduced strategies to reduce anxiety in children and raise awareness of the consequences of anxiety and by offering practical techniques to allow the effective detection, management, reduction and prevention of anxiety in children receiving medical care. The training had just been accredited for 6 CPD (continuing professional development) points with the Royal College of Anaesthetists. This was an initiative supported by the surgery division where approximately 30% of staff had received the training.

## Are surgery services caring?

Outstanding



We rated surgery services as outstanding for caring.

We found many examples to demonstrate that the hospital was delivering compassionate care. Parent feedback unanimously supported this. Emotional support was offered to patients, parents and staff. Parents told us they had a good understanding of the care their child was receiving and felt the hospital involved them in the care their children received. Friends and family test outcomes were also highly complimentary of the service.

### Compassionate care

- In the Friends and Family Test results published in December 2014 response rate was 30.47% (262 responses out of 860 patients) compared to a national average of 30%.
- To the core FFT question "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?" The trust performed very well with 99.2% of respondents saying they were likely or very likely to recommend the hospital.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. The patients and families we spoke with were generally very pleased with the care provided. They told us doctors, nurses and other staff were caring, compassionate, and responded quickly to their needs.
- The patients we spoke with were all very positive about the care they had received. One patient told us, "It's better than being in school, I come in three times a week. I love dancing with the staff". Another patient told us, "I have to come in for a check up every two years, it's a very good service, the doctors are brilliant and they're good at listening and explaining things".
- One parent told us, "It's 10 out of 10 as far as I am concerned, it's great". Another parent said, "It's the place we want to be at the moment, we feel safe here".
- We observed a large number of interactions between staff and patients and their families. We observed that staff were open, friendly and approachable but always remained professional. We observed that patients and families were often delighted when they saw staff they knew and greeted them as if they were old family friends.



# Surgery

- To help patients with the process of coming into the hospital pre-admission visits can be arranged. This allows the patients to see the hospital and their ward before they are actually admitted.
- In some cases, patients are sent a 'picture story' that sets out in pictures, with a few words, the journey they will take from home into the hospital.
- We found many examples where staff had provided additional support for patients and families for example, ordering take away food, arranging car parking passes. Staff always work with families to ensure that patients' birthdays are celebrated.

## Patient understanding and involvement

- Parents told us they felt involved in the care their children received. We observed excellent communication between nurses, doctors, parents and children, where children and parents were given good amounts of information regarding their care.
- On Koala ward, there were wipeboards behind children's beds where children could document their questions for doctors ward rounds.
- One parent on Sky ward told us they had a good understanding of the care and treatment their child received and felt fully involved in their care. They told us they felt staff were approachable if they had any queries. Care plans were reviewed and up to date and showed parent and patient engagement in the care of their children.
- On Squirrel ward, parents with children that had been in hospital for more than two weeks had a dedicated weekly slot with the ward manager or deputy to talk through any issues; to get updates they had not received and to ask any outstanding questions.
- Parents had access to ward kitchens. The parent of one child told us they were allowed to make their own child's breakfast which had made a positive difference to their experience.
- A young people's forum had been set up which involved a theatre sister engaging with young people to look at what improvements theatres could make to enhance their experience.
- Friends and family test outcomes for March 2015 showed high scores in the friends and family test were being achieved with high percentages (85% and 100%) 'extremely likely' and 'likely' to recommend their care. Nobody said they would not recommend the care.

Comments given demonstrated how highly people valued the compassionate and caring staff and their gratefulness for the treatment their children had received.

## Emotional support

- Every two weeks a practiceeducators and psychologist facilitated a staff support group for all surgery staff. This was to support staff with some of the more emotional aspects of their work.
- There was also a coffee morning organised by the social workers for parents to get together to talk about their experiences.
- We observed the 7a.m. intake on to Puffin ward for day and inpatient surgery where 16 sets of parents and children had arrived for their appointments. Staff demonstrated an understanding of parents' and children's situation and worked well to lower people's anxiety, speaking to them in a kind and empathetic manner, working to take people who were more anxious through to their individual bays and calm the main waiting room. We observed a compassionate staff group working together to achieve this.
- On Sky and Bumblebee wards we found the clinical nurse specialist (CNS) was very supportive towards families and child psychologists supported children and families, pre-operatively, as needed.
- There were volunteers who assisted people in theatres and on wards. We spoke to a volunteer on Koala ward who worked one day a week. They told us they were made to feel valued and included and their role involved speaking to parents for emotional support and were there to help with any questions they may have.

## Are surgery services responsive?

Requires improvement 

We rated surgery services as requires improvemet for responsiveness to patient needs.

There was a backlog of patients waiting more than 18 weeks for surgery, with cardiac, orthopaedics and plastic surgery under the greatest pressure. This had been reduced through working with commissioners, who had given an amnesty on this target between October and December 2014. A summary report was run during our visit.

# Surgery

It showed cardiac surgery currently had the greatest backlog of 83 patients waiting more than 18 weeks. Orthopaedics and plastic surgery had 18 and 37 patients respectively. All other specialties were below 10. Initiatives were in place to work to reduce these numbers.

In May 2015, the trust had asked the intensive support team to carry out a review of referral to treatment (RTT) data. The initial findings were that the trust data was unreliable, mainly affecting patients for surgery and outpatients, and that there had been inconsistent application of the trust's patient access policy.

On the surgical intake unit, intake had been staggered to four times a day to reduce waiting times for parents and children. Surgery managed its own patients within its own beds which meant there were very few outliers which ensured better care for surgical patients. There was an effective process for investigating and learning from complaints as well as monitoring more general comments and compliments about the service picked up by PALS.

There were a number of measures in place to meet the needs of patients and families but the quality of premises facilities was variable such as drainage problems and toilets on some wards not at low level or child friendly. Other wards located in newer parts of the building were better and there was a plan to relocate all surgery wards to a new building currently under construction, thus remedying existing premises issues.

Systems and initiatives were in place that ensured patients' individual needs were being met. This included a nil by mouth reduction initiative, providing snack boxes post-surgery and organising staff to specific assessment duties. Meeting the needs of children with a learning disability had been a specific focus of the service and other special needs were also being met.

## Service planning and delivery to meet the needs of local people

- Within the hospital there was limited outside space for parents and children or staff and children. There was a roof garden and play garden. There was a park nearby that could be accessed only if accompanied by a child or with trust identification. The new block currently being built had been designed with a planned courtyard to improve access to outside space.
- There were limited facilities on some wards. For instance, on Peter Pan there was one bathroom, three

toilets, and a bedroom with ensuite facilities for a 16 bedded ward. There was nowhere apart from the bed space for parents to sit, or stay over. The ward sister told us they had to advise parents to go and sit in the hospital canteen. On Puffin ward there were 2 bathrooms for a ward of 18. Both wards had adult sized toilets and so were not low and child friendly. The dental and maxillofacial unit had space for six chairs, which was low for the capacity of the unit.

- Peter Pan ward was closed on the days of our inspection due to a sewage leak from the floor above. Drainage was a routine issue due to the age of the building and affected the ward on average twice a year.
- Facilities on Puffin ward included a room for taking weight and height as part of the assessment on admission, which also provided space for parents to leave pushchairs and suitcases they had brought with them in readiness for their child's stay. A pager system had been introduced to notify parents when surgery had been completed. This allowed parents to spend time in the café or out of the building during the procedure.
- There were four telemetry beds which were used for diagnosing and monitoring of epilepsy and seizure. There was a juniors/babies play room with a good range of toys. There was a quiet room which was used by family members and staff and for holding sensitive conversations. The kitchen was accessible for parents to use and was clean and well maintained.
- Parents were able to obtain parking vouchers from reception that entitled them to park in the surrounding streets in some restricted parking areas while their child was in hospital. Wards had open access to parents 24 hours per day and parents could sleep on a zed folding bed in their child's cubicle. Accommodation was also available free of charge in a purpose built block nearby. Parents also had access to ward kitchens.
- Bumblebee ward had a good welcome booklet. On Puffin, Woodpecker and Kingfisher wards, information leaflets we found were not designed to be age group appropriate but for parents.
- Puffin and Woodpecker wards had introduced 'dignity suits' as a pilot scheme. These were similar to pyjamas and used for when children went to theatres. They had Velcro strips that allowed for only the appropriate part of the child's body to be exposed during procedures. The service carried out a survey to determine what children, and young people, thought of them. The suits proved very popular to the point of patients wanting to

# Surgery

own their own suit. The trust responded by purchasing more of the suits and in a wider set of sizes. We were informed they were soon to start selling them in the hospital shop due to the demand from parents and children wanting to take them home.

- Commissioned services were national and international. There were links with local providers and community nurses for discharge planning. The children were discharged back to where they were commissioned from and the team liaised with the local community team or acute trust prior to discharge. Discharge planning took place with international hospitals. On the private unit there was a specific discharge liaison team.

## Meeting people's individual needs

- Puffin ward had introduced an initiative to reduce the amount of time children were nil by mouth prior to their operation through better scheduling of individual operations on theatre lists. Parents were called the day before, once the time of their procedure had been confirmed. This initiative had proved successful in reducing nil by mouth times from an average of seven to five hours. On Sky ward we found the initiative to reduce nil by mouth times was now being trialled. Snack boxes had been introduced on the day case unit to assist the fasting patient following surgery. Prior to admission children and parents were asked about their preferences for a lunchbox which were then made up individually. Feedback to this initiative had been very positive.
- On Puffin ward staff were assigned to individual tasks to best meet people's individual needs. One healthcare assistant was dedicated to greeting parents and children, taking weight and height and leading them to their cubicle which had been allocated prior to arrival. Once checked in, a play worker or play specialist would visit the cubicle and bring toys. The ward manager told us that 90% of children were discharged within an hour as the role of Puffin ward was to admit and take to theatre. All cubicles had an entertainment system (television). Once in the cubicle, a SHO would clerk; a registrar or consultant took consent, and a nurse or HCA admitted. Once checked in, a play worker or play specialist visited the cubicle and brought toys. There was always a double check by a different nurse at 'sign out' to theatre.
- Names were placed on cubicle doors prior to arrival along with a named nurse so that children, and parents, were aware. There was also a checklist on the door which ensured that anaesthetist, clerking, consent, named nurse, play specialist, audio, echo, ophthalmology and any other checks had taken place. We discussed the issue of confidentiality of this with the ward manager. They told us that this had been weighed up in balance with patient and parent need and orientation.
- If a patient was identified as having a learning disability this was flagged on the system to enable staff to meet their individual needs. If this was not known prior to their visit it was escalated to the clinical team. There were learning disability link nurses for all wards and departments. The link group met monthly for the whole hospital. Any special need was flagged up in pre-assessment, which was then communicated to wards and theatres. This enabled a better understanding of individual needs such as hearing impairment or psychological need. Social workers were attached to surgical wards to assist with individual support needs.
- Approximately 40% of children coming through Puffin ward had a learning disability and Puffin had worked to improve meeting the needs of these children. All families were phoned the day before for confirmation of appointment and fasting times. If children had a learning disability, parents were asked what reasonable adjustments could be made such as the lighting being lowered in cubicles, not liking the surgical gowns and having a photo id instead of wristbands. Preferences were also noted such as how close to stand to the child. 'Sing days' with Makaton took place (Makaton uses signs and symbols to help people communicate) and all staff had learned Makaton. The ward manager was due to present the Puffin ward initiatives to an RCN conference later that month.
- There was a play worker and a play specialist allocated to each ward. Their work included coordinating activities and working by the child's bed and distraction prior to theatre, investigation and cannulation.
- Language support, in the form of face-to-face interpreting, telephone interpreting and written translation was all available. Interpreters rather than family members were used. We spoke with the parent of one child who told us they were very happy with their care. They told us nurses went to great lengths to ensure

# Surgery

that their child was comfortable. English was their second language and they were offered an interpreter but felt this was not necessary. On Bumblebee ward, which was an international private patient ward, we found two Arabic advocates on site, whose role included translation. We were told the ward required a big translation input due to the language needs of its patients and parents.

- On Sky and Bumblebee wards we found the menu was varied. The food trolley came in before midday and before 5 p.m. and staff served patients depending on choice of food on offer and portion size. Snacks were also available.
- On surgical wards there was a choice of four lunch options that included fresh vegetables.

## Meeting the needs of adolescents

- There was a range of services and facilities available for young people.
- On Koala ward, the neuroscience unit, there was the transitional care policy which we were told was new. The unit kept craniofacial patients up to the age of 21 as adult services were still not familiar with the specific surgery. There was an adolescent room that was well equipped with media equipment, books and posters.
- Both Sky and Bumblebee wards had an adolescent room with games and a television.
- In pre- assessment, staff we spoke with had no knowledge of transitional care pathways.

## Access and flow

- A summary report run during our visit showed a breakdown of patients who had been waiting more than 18 weeks for a 'to come in' date. Cardiac surgery, showed the greatest backlog of 83 patients waiting more than 18 weeks. Orthopaedics and plastic surgery had 18 and 37 patients respectively waiting more than 18 weeks. All other specialties were below 10.
- Between October and December 2014, the surgical directorate had worked with the NHS England Commissioners to reduce the backlog of patients who had been waiting over 14 weeks for treatment, during a period of amnesty against the Admitted Target. During this period of time the surgery directorate investigated those patients waiting over 14 weeks and reduced the waiting list from 208 patients to 103 patients.
- Since January 2015 the trust no longer had this amnesty but the directorate continued its targeted work on the

longest waiters and prioritising these patients. In specialties where capacity did not meet demand, such as plastic and orthopaedic surgery, the trust was liaising with the clinical teams and also engaging with the South East Commissioning Support Unit for their support on a sustainable longer term model. The clinical lead for general surgery told us they were looking to develop off site capacity to perform day case surgery in local district general hospitals, with one location already identified and talks ongoing with three other London hospitals about a similar arrangement. This was to address capacity issues for non-complex surgery.

- The initial intensive support team review of RTT had also identified inconsistent application of the trust patient access policy. Action was taken to obtain expert resources to lead an improvement programme to remedy this.
- Statistics presented showed theatre utilisation for the last three months of 2014 running at between 50 and 70%. The theatre management group met quarterly and brought together leaders from all three hospital divisions which had surgical activity; cardiac and critical care, neurosciences and general surgery. One of its functions was to look at how theatre time was used and allocated. Minutes from May and October 2014 show the group discussed utilisation, cancellations and theatre performance. However, the group had not met since October 2014. This was due to the group not having an executive member in attendance.
- A weekly 'office manager's meeting' went through all surgical activity and looked at patients who had been waiting longer than 18 weeks that were surgery patients. The patient information management system (PIMS) was a scheduling system that relied on waiting list managers communicating with theatres. There was an MDT meeting held monthly within theatres which discussed the scheduling of theatre lists. This included provisional planning for the next 2-3 weeks. A theatre scheduler ensured that lists were adequately populated. Work was taking place on developing a new IT system that booked beds for patients at the same time as their theatre and surgery was booked.
- In theatres, we were shown a print out of the theatre schedule which included any vacant lists. The vacant lists occurred if the surgeon was away. It was offered to others within the same speciality six weeks in advance. It was then offered to others at four weeks if not filled.

# Surgery

- Gastro interventional services ran eight lists a week, 46 weeks of the year. Each list was of 3 to 10 cases. This was a mix of day and inpatients. Staff felt that capacity was always an issue with demand for the service high.
- The pre assessment clinic was a new facility that had been recently opened. There were presently 15 patients a day which was intended to rise to 60 when fully operational. It had been designed to fit in to the available space and had little seating for waiting patients. A pager system had been introduced so patients could be called back when a space was available for them. Waiting time was already up to 15 minutes and due to get longer when up to full speed. This was down to mixture of space constraints, staffing levels and processing times.
- Intake to Puffin ward, for both day and inpatient surgery, had been staggered to occur four times a day. This meant patients were now being admitted to the corresponding number of cubicles available at any one time, which meant children had less waiting time. It had previously been two intakes a day which had led to the waiting room often being busy and disrupted with children and parents becoming more anxious about the procedure due to a longer wait.
- On Puffin ward, a large screen monitored patient flow through the hospital. It stated when surgery was ready to accept each patient and when they had gone to theatre. It also stated fasting, time of last fluid, the theatre they were going to, time of arrival in the unit and ward location. There was room for comment by staff which was abbreviated for patient confidentiality.
- We observed Puffin ward staff telephoning other wards to confirm a bed for each child following being booked in. Only once a bed had been confirmed patients would go to theatre. Daily bed meetings took place at 9 a.m. and 2 p.m. and if operations had to be cancelled due to bed pressure they tried to do this a day in advance thus causing less distress for the family. We were also told that the short stay ward had been closed a couple of months previously for reconfiguration to a private ward which had placed greater pressure on beds. The trust subsequently told us that this was for a reconfiguration of ward areas.
- The clinical lead for general surgery told us they had approximately 10-15% of patients who were outliers on other surgical wards but none on other wards outside of surgery. This ensured good surgical nursing skills rather than patients being on medical wards. A consultant

urologist told us that 30% of urology patients were outliers in other surgical wards as they did not have enough beds to manage their own activity. However, patients were rarely cancelled due to the lack of beds. Hopes were pinned on moving to the newly built unit currently under construction where bed pressures should be eased.

- We spoke with the parent representative who sat on the senior management team meetings for surgery. They told us they had attended senior team meetings for surgery since 2010. One live issue they mentioned was clinical letter turnaround times that had led to increased non-attendance rates due to parents not receiving letters on time. Depending on which member of staff you spoke with, we were told this was either based on a reduction in administrative staff or it was taking a while to get consultants to sign off letters. In maxillofacial and dentistry we were told they were trialling electronic signatures as a way of reducing the delay in getting clinical letters signed.
- On Koala ward there were no concerns regarding the transfer of patients to local hospitals. There were occasionally delays in relation to children with complex needs which needed to wait for an appropriate bed or occasionally rehabilitation which was in short supply. Two parents told us that telemetry care was well coordinated with other investigations such as MRI scanning so there was less travelling to the hospital for separate things.

## Learning from complaints and concerns

- When a complaint was received by the central complaints team, it was logged and forwarded to the HNS who decided on the most appropriate person to investigate. The HNS telephoned all complainants in the first instance, in the spirit of openness and candour before conducting an investigation. They reported back to the central complaints team, who reviewed the report for thoroughness and whether it addressed the points raised. The complaints team also monitored the complaints handling timescale.
- Trust complaints analysis demonstrated that all complaints were logged by description, outcome, action and department. Dates were also recorded to check progress against timelines. The LIMB group also reviewed complaints. Minutes from February to April 2015 demonstrated that complaints, PALS feedback and themes arising were brought to this meeting.



# Surgery

- Weekly team management meetings in surgery reviewed all complaints as well as PALS information regarding complaints, compliments and general comments about the service. Any trends or live issues were picked up. We found a number of examples of the complaints process in operation. On one surgical ward, feedback and complaints from some parents had led to the nursing structure to be changed, with deputy ward managers introduced and band 7 nurses made supervisory. On Bumblebee ward we found told that a recent complaint had involved an issue of expectation around complex issues. As a result the way they communicated with the parents had changed.
- On Sky ward we found complaints and comments displayed outside the sister's office, which was an area of the ward parents were unlikely to access. This was on an A4 sheet and written in small print, located up high and was difficult to read.
- On Bear ward (cardiac) complaints were dealt with by the ward manager for resolution and that complaint forms were available on all wards. PALS were also on hand to assist with complaint issues and staff would also signpost people to PALS. Any complaints made were fed back to ward sisters with learning communicated in team meetings.

## Are surgery services well-led?

Requires improvement



We rated surgery services requires improvement for being well-led.

There examples of good practice. For example there were clear visions and strategic priorities that were signed off by the trust board. There were clear lines of leadership and accountability through clinical specialties, theatres and surgical wards. There was also a clear governance structure.

We found an open and transparent culture with motivated and compassionate staff. We were told about a case of bullying in one department which was dealt with by the departmental clinical lead.

The chief executive of the trust met regularly with the surgery leadership to understand the live issues and affect change where this was achievable. A parent representative sat on the senior management team meetings for surgery.

However we were concerned in relation to issues found in referral to treatment (RTT) data reliability, management and reporting which had happened over a period of several years.

## Vision and strategy for this service

- We were presented with the annual plans for the three hospital directorates that carried out surgical activity; general surgery, neurosciences and critical care, cardio and respiratory. Documents addressed topics under the general headings of patient experience, quality, safety, financial and workforce related issues. Visions included having the best patient outcomes, to be a world leading paediatric research centre, and to be financially sustainable. Strategic priorities included improving patient pathways, recruitment and retention of staff and improve external relationships with commissioners and other providers.
- The divisional plan for surgery included delivering good clinical outcomes for patients, working within clinical networks and partner providers, streamlining patient pathways and continuing with the improvement of patient accommodation. Continuing to develop the workforce's knowledge and skills and improving productivity were also highlighted.
- The senior management within the surgery division told us that all strategy documents had been signed off by the board but were subject to change. This was in line with remaining responsive to the needs of commissioners and other providers in the changing face of providing a service that was required by strategic partners. This included meeting the needs of patients with regard to transferring patients to the local hospital and providing staff with the necessary skills required for this to occur.

## Governance, risk management and quality measurement

- There were three hospital divisions that included surgical activity; cardiac and critical care, neurosciences

# Surgery

and surgery. The 'theatre management group' met quarterly and brought together leaders from all three hospital divisions which had surgical activity; cardiac and critical care, neurosciences and general surgery.

- There was a clear governance structure that showed the quality and safety board, the infection control board and the nursing board feeding in to the divisional board meeting for surgery. Governance meetings for individual surgical specialities also fed in to this meeting. Risk action groups fed in to the quality and safety meeting. Minutes of these meetings demonstrated that key managers were in attendance and that action and follow up was taking place.
- There was a senior management team meeting for surgery and senior management team meetings for trust. Trust senior management team meetings were chaired by the chief executive and occurred fortnightly. The surgery leadership attended these meetings.
- The risk register for surgery showed that risk issues were being identified and action taken to reduce those risks. This was updated at regular intervals along with a brief description of action that had been taken and action that was planned.
- We spoke with a parent representative who told us they regularly attended surgery senior management team meetings where risk management issues were discussed. They told us they felt that staff had a genuine desire to improve the safety and quality for children through action.
- Audit plans for surgery were decided on in conjunction with trust audit coordinators and managed through the learning, implementation and monitoring board (LIMB) who also reviewed the audit plan.
- We were concerned that issues in relation to referral to treatment (RTT) data had not been picked up sooner.

## Leadership of service

- Within surgery there was a divisional director, a service manager and a head of nursing for surgery (HNS) leading the division. There were two lead nurses, one for theatres and one for wards who reported directly to the HNS. Each ward had a ward manager and deputy managers, allowing for a consistent approach when ward managers were not on duty. All managers worked 50/50 between specific management tasks and clinical duties. Each surgical speciality had a clinical lead for that area.

- Staff we spoke with on surgical wards told us that the executive team were visible on the wards and staff knew members of the executive team. The trust chair was well known on Bumblebee ward as they won a team of the year award and met with her to accept the award.
- A senior sister on Woodpecker ward highlighted to us that the senior management team for surgery were supportive. We were given examples of this which included redesigning staffing and the day case unit to meet patient needs better.
- Once issues in relation to RTT data and processes had been identified, a remedial action plan was set up which included recruitment of experts to lead an improvement programme; validating underlying RTT data; clinical review of patients and retraining of clinical and non-clinical staff to improve RTT recording and ensure consistent application of the patient access policy.

## Culture within the service

- On Sky and Bumblebee wards, staff felt there was an open and transparent culture with staff and parents. Leaders of the service were known to staff who felt they were approachable. Staff were also aware of the whistleblowing policy and process. Theatre staff we spoke with felt that if they wanted to discuss and issue or change something due to its risk, they were listened to by theatre and surgery managers. Ward clerks told us the hospital was a 'happy place' to work.
- A lead cardiothoracic surgeon told us that there remained some disconnect with hospital management who did not understand the complexity of cases or appreciate the scale of the workload and did not listen to some clinical arguments made by surgeons. However, they felt the surgical department was highly motivated, compassionate and driven in their work.
- A member of staff told us that some staff in surgical specialties had experienced bullying. We discussed the issue of bullying with a lead cardiothoracic surgeon. We were told that two incidents had been reported to them and they had interviewed individuals about whom complaints had been made. We were given explanations regarding the nature of the complaints and how these had been dealt with by the surgical lead. Both individuals had been told about the organisation's cultural norms and expectations about their behaviour with both staff and patients and informally told to improve.



# Surgery

- We spoke with the HNS regarding bullying within the surgical division who told us they were not aware of any bullying and stressed the open culture they tried to promote.







## Public and staff engagement

- A parent representative sat on the senior management team meetings for surgery. They told us they felt listened to by the surgery leadership, who were responsive to issue raised, which also got followed up.
- Puffin ward had been opened a year at the time of our visit and the ward had introduced a patient feedback questionnaire, which was available at reception and also sent out to patients six weeks after the visit.
- Friends and Family test outcomes for March 2015 showed that high scores in the friends and family test were being achieved with high percentages (85% and 100%) 'extremely likely' or 'likely' to recommend their care. However, response rates were lower than the department would have liked, averaging at 28% of discharged patients. We spoke with the HNS about action taken to improve these response rates. Ward clerks were now being managed by ward sisters instead of within an administrative structure. This was to promote their inclusiveness within the ward teams, which included promoting the collection of data with regard to Friends and Family.
- Recently surgical staff attended the young people's forum and speak about the introduction of the dignity suits. They had also engaged with the young people's forum regarding preferences on how they wished to be spoken to and treated in the context of a hospital specialising in treatment of small children.

## Innovation, improvement and sustainability

- The Children's Hospital Alliance for Real Innovation in Operating Theatres (CHARIOT) was a partnership forum of specialist children's hospitals that included Alder Hey, Bristol, Manchester, Birmingham and Leeds and this trust. The group had looked at group procurement of specialist items for economic expediency. It had also more recently looked at competencies in theatres for HCAs. Practice educators supported staff in theatres and had also met as part of this group and were working towards accreditation for paediatric recovery.
- The general manager and divisional director for surgery had monthly meetings with the chief executive. This was to talk about any 'live issues' and updates. We were given examples of how this had helped to move on a couple of things such as restructuring some aspects of staffing and renovating a theatre. We were also told that leadership within surgery was being restructured as a result of these meetings. Instead of having many clinical leads based on speciality there was to be one clinical lead with more time to devote to a leadership role.
- We spoke with the parent representative who sat on the senior management team meetings for surgery. They told us they had attended senior team meetings for surgery since 2010. The nil by mouth (NBM) initiative was influenced by their input following their own child's experience, although it had taken four years from the idea's inception. Before this they told us the NBM process met the surgeons' needs rather than the child's so it had taken a while to get off the ground but was now being rolled out across all of surgery. They also told us they felt listened to by the surgery leadership, who were responsive to issue raised, which also got followed up. They felt it was a well run division because of the commitment of its leaders.

# Critical care

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

## Information about the service

There are three critical care areas at the hospital - Neonatal (NICU); cardiac (CICU) and paediatric (PICU). The Paediatric Intensive Care Unit (PICU) provides general paediatric intensive care. NICU provides neonatal intensive care and CICU provides cardiac intensive care. PICU has 24 beds. There are nine separate rooms, two double cubicles and the remainder of the beds are in bay areas. Additionally high dependency areas are part of Squirrel and Bear wards which act as a step up or step down service for NICU.

Children requiring intensive care receive one-to-one nursing care while those receiving high dependency care are cared for on a ratio of two patients to one nurse. The PICU has around 1200 admissions annually. An acute pain team works throughout the trust and is available to the units for the management of critically ill children.

The children's acute transport service (CATS), is hosted by the trust but the service is located off site. In 2013/14 the service transferred 1209 children of which 76% of these were ventilated. The majority of transfers 470 (40%) were transferred into the trust; the remainder were transferred to other paediatric intensive care units.

We spoke with 8 parents and 37 staff members including, nurses, doctors, consultants, senior managers and support staff. During the inspection we looked at care and treatment, we also reviewed care records. Before and during our inspection we reviewed performance information from and about the trust.

## Summary of findings

There were systems and process in place to promote safe and effective care. There was a formal escalation process in place for managing deteriorating children and young people. Incidents were reported, investigated and learning took place. Nurse staffing levels were in line with national guidance. Staff had access to a range of training and professional development, ensuring they were competent for their role.

Policies and guidelines were based on NICE and other relevant national guidelines. The service participated in local and national audit including PICANET. The unit's capacity and flow was managed effectively. There was a vision for the development of the service and identified nursing and medical leadership.

# Critical care

## Are critical care services safe?

Good



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

There was a formal escalation process for managing deteriorating children and young people. This included the clinical site practitioner service, hospital at night team and the intensive care outreach network (ICON). The trust had implemented the children's early warning score system (CEWS) and the use of the Situation –Background-Assessment –Recommendation –Decision (SBARD) communication tool to identify record and report signs of deterioration in children.

### Incidents

- Staff we spoke with told us that they used an electronic incident reporting system. They said there was a transparent culture of reporting all incidents including those considered to be minor. We saw evidence that 268 incidents were reported between October 2014 and January 2015. Staff gave examples of when they had reported an incident and the email confirming that the incident had been logged.
- The CATS annual report for 2013/14 stated that the team had reported incidents that occurred during transfers, these included issues relating to ambulances and equipment. Each incident had been analysed and discussed during the daily team huddle, where clinical activity from the previous 24 hours was discussed.
- All medical and nursing staff we spoke with were aware of the actions taken when an incident occurred. These included reminders being sent by email to all staff, individual involved in incident being asked to complete a DIARY tool to analyse and reflect on the incident.
- Following incident investigations, the findings and learning were cascaded to all staff through a range of different methods. These included, for serious incidents, a one-page summary and root cause analysis report, patient safety messages issued on a weekly and monthly basis and internal patient safety alerts circulated for issues of particular concern.
- Changes to practice following incidents were cascaded to staff members via emailed safety reports. These included details of the incident and the subsequent learning. The trust governance team was responsible for cascading these post incident safety reports.
- The head of the patient advocacy and liaison service (PALS) told us that young people and their parents were kept informed about incident investigations. A parent we spoke with confirmed that PALS had been very helpful and kept her fully informed after she had raised a concern about her child's care in another part of the hospital during a previous admission.
- The cardiac surgical service meeting we observed included a discussion about all the incidents and recommendations that had occurred. At this meeting progress of implementing changes post incidents was also reviewed.
- The head of clinical governance and safety explained the mechanisms for responding to clinical incidents. The serious incident investigation reports we saw demonstrated that recommendations had been made and discussed at the weekly mortality and morbidity meetings.
- There were over 50 individuals from all levels of staff including medical, nursing and allied health professionals at the multidisciplinary mortality and morbidity meeting we attended. All cases were presented and discussed in detail. We observed that this meeting also discussed standing agenda items such as hospital acquired infection, re-operations, transfers from other centres and readmissions to the PICU. All mortalities occurring in the unit were discussed. The minutes and output from these meetings were reported to the trust audit committee and the clinical governance committee.
- All staff we spoke with were aware of their responsibility in relation to the duty of candour. We found examples of this knowledge being used in practice including one parent we spoke with who had received an apology from a senior member of staff after raising a concern about her child's care in another clinical area in the trust.

### Safety monitoring

# Critical care

- The unit had developed systems to increase consistency in care such as care bundles, standardised processes and safety huddles.
- There was continuing monitoring of skin integrity. We were told that staff used the GOSH paediatric pressure ulcer risk assessment tool to monitor skin integrity in vulnerable patients. Incident forms were completed for any child with skin deterioration. Observations were recorded hourly to four hourly depending on the child's needs.

## Cleanliness, infection control and hygiene

- The unit was visibly clean with dedicated cleaning staff provided by an external company. Staff we spoke with told us the cleaning staff were responsive. We observed cleaning requests made by nursing staff were responded to in a timely manner.
- The trust-wide infection control policy included guidance on which children and young people should be isolated in a cubicle. For example, the cardiac intensive care unit had three cubicles which were used as isolation rooms for children who were infectious or at risk of infection.
- The consultant microbiologist undertakes a ward round on the critical care unit three or four times a week to review microbiology results and infection control requirements. The IPC team and on call microbiology service are available 24 hours a day for advice on whether a child or young person should be isolated.
- There was an annual infection control audit programme that include monthly hand hygiene and care bundle audits as well as an annual urinary catheter audit. All audit results were submitted using the electronic audit data collection tool via the trust's transformation website by the last day of each month. The findings of these audits were reported in the annual infection prevention and control report.
- The unit had an identified infection prevention and control link nurse. All staff had been trained in hand hygiene and every month, the link nurses audited compliance to the hand hygiene protocol.
- The results of the infection control audits were displayed in the corridors and on ward based dashboards. The infection prevention and control annual report 2014 shows that compliance rates for hand hygiene have increased but were still below 100%, across all clinical areas
- All staff we saw during our inspection adhered to the bare below the elbows policy, as well as utilising appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities.
- There were sufficient numbers of hand washing sinks on the unit including a non-touch dual hand washing sink outside the critical care unit for staff and visitors to use before entering. We observed that doctors and nurses washed their hands before delivering care and used the hand sanitizers frequently.
- Throughout the unit we noted visible wall mounted notices promoting hand sanitation.
- Parents we spoke with told us that the nursing staff had shown them how to wash their hands before contact with their children to avoid cross infection. They also told us that the doctors and nurses frequently washed their hands.
- We were informed by the practice educators and staff we spoke with that Infection control training was part of mandatory training that all staff were expected to complete. Training data seen for critical care and cardio-respiratory division demonstrated that 76% of all staff had completed level 1 training.
- Nurses were responsible for cleaning equipment at the bed side daily, and we saw that this was recorded on the electronic recording system.
- The infection control clean sheet, that recorded cleaning of an isolation bed space, completed by housekeepers demonstrated compliance with the aims and objectives of the hospital infection control team to reduce the risk of cross infection.
- Following a child's discharge all cots and beds were taken to a cleaning room (Medical Equipment Disinfection Unit) in the basement of the hospital for cleaning to prevent cross infection.

## Environment and equipment

- Entry to the critical care unit was via keypad entry with CCTV coverage to allow staff to observe for "tailgater entry"
- Staff told us that all equipment was checked and cleaned before being returned to the hospital departments by the electro bio-medical engineering department [EBME].
- The hospital had an asset management system which utilised radio frequency (RFID) identification to track equipment loaned from the asset library. This system

# Critical care

had a built in warning system to alert engineers when RFID batteries were within two months of expiry. When equipment was returned to the library the RFID system alerted engineers within the EBME department that it was available for scheduled maintenance.

- Resuscitations trolleys were checked daily. The records seen of these checks found that they had been appropriately checked and replenished as required.

## Medicines

- There was a hospital wide medication policy and staff we spoke with were aware of policies pertinent to the administration of medicines to babies and children.
- The designated pharmacist attended the unit daily (Monday to Friday) to review patients and their medications to ensure that they were suitable and within prescribing guidelines.
- The pharmacist told us prescribing procedures were satisfactory. The antibiotic prescription charts we reviewed were all prescribed correctly.
- Senior nurses confirmed that medication storage was safe and we inspected the medication dispensing cabinets in the critical care unit and noted that storage was safe in terms of access.
- We noted that drug fridges were locked and daily temperature checks were completed and records kept of these checks.

## Records

- Patient records on the critical care unit were recorded electronically on a central database.
- We found that the sample of care records we reviewed were complete and included individual care plans, a summary of the care delivered and a record of the child's observations. They were legible, dated and signed, and recorded the staff member reviewing the child.
- Staff reported that navigating the several different hospital IT systems was time consuming. In some cases if an electronic patient record had not been closed down, it could not be accessed by another professional.
- The four sets of medical records we reviewed provided a full record of the child's plan of care and any investigation results.

## Safeguarding

- The trust had a safeguarding policy which reflected national guidance and had been regularly reviewed.

- In line with national guidance there was a policy and procedures for celebrity visitors. A staff member acted as a chaperone for these visitors to ensure they were never left alone with children. The nurses we spoke with were familiar with these procedures.
- There was a local (CAMHS) guideline for the management of the absconding child. The processes had not been tested to evaluate its effectiveness.
- There was a designated trust safeguarding team that included a named doctor and nurse and two safeguarding nurse specialists
- The chief nurse was the lead executive director for safeguarding children and young people and chaired the safeguarding children group which reported to the trust board.
- We saw evidence that all staff employed at the trust had a DBS check prior to employment.
- All medical and nursing staff we spoke with told us that they had attended the appropriate level of safeguarding children training. Training records held at divisional level (critical care and cardiorespiratory) demonstrated that 97% of staff had completed safeguarding level one, 90% level 2 and 96% had completed level 3 safeguarding training.
- Staff were provided with safeguarding children update training on an annual basis. The housekeeper we spoke with stated she had received safeguarding updating and that she had been informed that she was required to attend this training via email.
- The staff we spoke with were able to describe the process for reporting any concerns to social services and were aware of the procedures to follow should a safeguarding issue arise.
- For children at the hospital for longer periods, after 3 months, the child's local authority is informed and asked to assess the child and family's additional needs.

## Mandatory training

- The trust identified 28 mandatory training modules that staff were expected to complete including safeguarding and resuscitation. The level of training was dependent on the individual staff members role but there was a 95% completion target set for all modules,
- There was a range of topics that were considered mandatory for qualified nurses. These included medicines management training, pain management techniques (PCA, NCA and Epidural). Records showed



# Critical care

that for some course such as pain management techniques, only 60% of staff across critical care and cardio-respiratory division had completed this training which was below the 95% target.

- There were designated practice education facilitators (PEF's) on the critical care units. They maintained a record of the mandatory training completed by staff.
- Staff received advance emails reminding them of scheduled mandatory training updates.
- The nurses we spoke with stated it was difficult to make time to complete mandatory e-learning modules.
- All nurses we spoke with said they had completed induction training on commencement of employment, but we were not provided with evidence to support this.

## Assessing and responding to patient risk

- In monitoring children for signs of deterioration the unit used a one to one nurse to patient ratio and a low doctor to patient ratio. The ICU does not use CEWS; however CEWS are used on the HDU and other wards across GOSH.
- All children on the critical care unit were assessed using the child safety thermometer and SBARD as required.
- Throughout the critical care unit, electronic patient data boards were displayed showing a range of clinical information. Staff we spoke with stated they found these to be helpful in overall patient management.
- The clinical site practitioners (CSP) provided the outreach service to the wards, 24 hours a day, seven days a week, assessing and responding to deteriorating patients outside the critical care units. They also led the resuscitation team in the event of a patient collapse.
- The CSPs used a Situation, Background, Assessment, Recommendation, and Decision proforma (SBARD). This was available on all wards, when discussing children who may be deteriorating, with ward staff when agreeing treatment decisions. We were told all staff knew how to use these proformas for the CSP consultation. We observed such an assessment of a neonate who had been identified for monitoring.
- The CSP team also provided ward staff with telephone advice. Any child observed as deteriorating was flagged by the team and seen during the regular CSP rounds. We observed that during the CSP round children were assessed and staff provided with advice or if appropriate transferred to a critical care unit following discussions the critical care intensivists.

- We were informed by a consultant that new policies had been developed to ensure that babies in HDU were monitored to detect any deterioration which might necessitate transfer to critical care.

## Nurse staffing

- Nurse we spoke with said there were sufficient staff to meet the needs of patients. Staff rotas showed the numbers of staff scheduled to be on duty and the system was updated with the actual names and numbers required to meet the planned activity. These met the national staffing guidance provided by the Royal College of Nursing and the paediatric intensive care standard.
- We saw that all children requiring level 3 care received 1:1 registered nurse support. Those requiring HDU/ level 2 care were nursed on a one nurse to two patient ratio.
- There was a designated supernumerary nurse in charge for every shift and any staff sickness and vacancies were covered by bank staff. They were usually the unit's own staff who wished to work additional hours.
- The majority of parents we spoke with told us that they were confident that there were enough doctors and nurses on duty at all times to care for their sick child.
- There were some vacant band 6 nursing posts and we were told that there had been difficulties in recruiting to this grade. Sickness and vacancies were covered by the hospital's nursing bank. Most were existing or former staff.
- Nursing staff informed us that there was an internal movement of staff across the critical care units to enable them to respond to skill mix challenges as necessary.
- We were informed by the critical care practice educators that all nursing staff working within critical care had completed advanced paediatric life support training for paediatric or neonatal resuscitation. However, we were not provided with training records to demonstrate this.
- Nursing staff were supported by health care assistants who had completed specific critical care competency based training developed by the PEFs.
- While there were many specialist nursing roles such as the tracheostomy nurse, we saw no evidence of succession planning.
- All nurses worked 12 hour shifts and there were two nursing handovers daily at which all nurses were given a written print out of all the patients being cared for on the unit. This detailed the child's individual care plan.

# Critical care

- The head of nursing for critical care attends nursing hand overs. We saw the head of nursing during an early morning handover on the neonatal unit verifying with the senior clinical nurse on duty that there were sufficient staff.
- The CSP held separate handovers twice daily with the hospital at night team to ensure all staff were aware of children who may need additional support.

## Medical staffing

- The service had 24 hour a day, seven days a week intensivist consultant cover.
- Doctors we spoke with told us that medical cover met the needs of children. The night cover was orientated around the hospital at night team which included clinical site practitioners and rotational medical staff including the Intensive Care Outreach Network (ICON) and anaesthetists.
- The ICON was established in 2012 and consisted of a dedicated consultant and six ICON/ICU fellows to provide a seamless link between the intensive care units, high dependency units and wards throughout the hospital. This service was fully integrated into the hospital at night and CSP service.
- There were two medical handovers every day. The late evening handover we observed was led by one of the general paediatricians and provided an overview of activity in the trust. However, we noted anaesthetists did not attend these meetings.
- All middle grade doctors and consultants had completed the APLS advanced life support course and, if necessary, had attended APLS update training.

## Major incident awareness and training

- The trust had a major incident plan including local emergency resilience actions to be taken in the event of such an incident. The CATS childrens ambulance service had their own plan that included their responsibilities in the event of a major incident including a vehicle accident.
- Staff we spoke with stated that the local emergency preparedness resilience policy had been tested for effectiveness.
- Plans were in place for a wide range of issues such as the loss of utilities, loss of staff, communications, IT and the emergency call system. In the event the unit needed to be evacuated alternative locations had been

identified as suitable to accommodate level 2/3 patients. This plan was put into operation when a fire which broke out in the cardiac wing in 2008 and 40 children were successfully evacuated.

- We were informed that winter and summer resilience management plans were fully operational to cope with, for example, seasonal variations in morbidity within the childhood population.

## Are critical care services effective?

Good



Policies used were based on NICE and other relevant guidelines. These were regularly reviewed and updated to ensure they reflected any changes in practice. Staff participated in a wide range of clinical audits and research. The use of care bundles was embedded and patient outcome data were monitored and benchmarked with other children's critical care units via the PICANET national database.

There was a structured induction and development programme for all staff who had the skills and experience to deliver effective care. Care was delivered by a multidisciplinary team who utilised their individual skills and knowledge. Services were provided 24 hours a week, seven days a week to meet the needs of the children and their families.

## Evidence-based care and treatment

- Policies and care bundles used in critical care were based on NICE and professional guidelines such as the intensive care society standards. These policies were regularly reviewed and any changes identified through a variety of mechanisms including information elicited from the paediatric intensive care audit network monthly newsletters
- All staff we spoke with confirmed that they had easy access via the trust intranet to policies and procedures. We were able to access the data base of policies and procedures via the unit computer. We reviewed the pain protocols by this method.
- We were told and observed that medical staff could access trust protocols via their mobile phones which provided them with instant access to the protocol data base.



# Critical care

- There was an annual audit plan that included a range of audits including patient outcome audits. Each audit had a start and end date as well as an identified lead clinician.
- The service ensured adherence to local best practice guidelines through a variety of activities ranging from regular staff meetings to education and training provided by the critical care clinical education facilitators
- The service monitored compliance with critical care bundles through audit. We were told one of the consultants had published a paper in a professional journal about using care bundles to prevent infection in neonatal and paediatric ICUs.

## Pain relief

- The unit had access to the trust wide pain team which included a consultant and six clinical nurse specialists. One of the nurse specialists was the identified link nurse with the critical care unit.
- Children's pain was assessed and managed in conjunction with the pain team.

## Nutrition and hydration

- There was a paediatric dietician who undertook weekly ward rounds on the critical care units to identify any potential issues with nutrition and ensured these were addressed.
- Children's nutrition and hydration needs were assessed and met through a range of clinical guidelines including the infant feeding guideline.
- We noted that records were kept of intravenous infusions, parenteral nutrition and the child's fluid balance, enabling staff to monitor the child's nutrition and hydration status.

## Patient outcomes

- The unit participated in a range of local national audits such as the paediatric intensive care national audit and research centre (PICNARC) to compare its performance and outcomes with other paediatric units.
- The PICANET information displayed showed that the intended outcomes for children receiving intensive care were being achieved. For example the mortality rate was 4.6%, which is line with other trusts who submitted data.
- We saw that the electronic data boards were effective in giving professionals up to date patient information such

as name and hospital number. They changed colour when the child was ready for discharge from critical care and displayed the number of days the child had been waiting for a bed on a ward.

- The service regularly reviewed the effectiveness of care and treatment through local audits such as psychological follow up of PICU patients and families and participation in the national paediatric intensive care audit.
- The CSP team had bench marked it's outcomes of deteriorating children in ward areas with another London children's hospital. This exercise found that the team and outcomes were similar to the other hospital.
- Care bundles, a group of three to five evidence based interventions, which when performed together have better outcomes for the patient, were used in critical care to promote the delivery of the best possible care for critically ill children and babies.
- The units shared a play therapist who worked with children to distract them during treatment or interventions.

## Competent staff

- At least 50% of registered nursing staff employed in the critical care units held a post registration qualification in critical care nursing.
- Staff we spoke with stated professional development opportunities were available and they were supported to attend training such as LSBU Critical Care courses, which were funded by the trust.
- The PEFs were supernumerary and worked with nurses at the bedside, supporting nurses to develop their clinical skills.
- We were told that all unit managers had completed appropriate intensive care training and held intensive care qualifications.
- All medical and nursing staff stated they had participated in an annual appraisal at which their learning needs were identified. The data provided by the trust showed that 68% of critical care staff had participated in an appraisal.
- To meet the specific learning needs of nurses the practice education facilitators liaised with local universities to access training courses and specific modules.

# Critical care

- Staff could apply for funding for professional development such as for specific modules or masters programmes, but obtaining funding could be challenging.
- The consultants we spoke with said that clinical supervision was provided for medical staff and this was confirmed by the junior medical staff we interviewed.
- We were told that the majority of health care assistants on the units were overseas registered nurses who were waiting to complete a university course which would lead to them obtaining their UK registration.
- To increase the skills of ward nurses the CSP team delivered bed side teaching when called to see a sick child in any part of the hospital, this ensured staff felt confident to deliver specific care the child needed.
- All staff had access to simulation-training sessions where manikins were available for resuscitation practice.
- There was a mentorship programme in place organised by the PEF for the supervision of undergraduate student nurses on placement in the unit to ensure they were facilitated to develop the skills required to care for sick children.

## Multidisciplinary working

- All staff we spoke with said that MTD working was effective in the critical care units. For example a senior physiotherapist told us that she had excellent working relationships with doctors and nurses. We observed effective MDT working between the CSPs and medical staff.
- We noted that bi monthly meetings chaired by a psychologist took place to promote MDT working. These were embedded as part of the critical care procedures.
- The CATS team members we spoke with described an MDT approach to patient care and transport. We observed this approach working effectively during our inspection.
- We observed collaborative working between the palliative care outreach team and the unit's staff to ensure children and their family's needs were met.
- There were daily MDT consultant intensivist led ward rounds with input from nursing staff.
- We noted that staff on the critical care unit worked together to assess and plan on going care and treatment in a timely way when children move between

teams or services. For example all children transferred from the critical care unit to high dependency care were monitored for 48 hours post transfer by members of the clinical site practitioner team.

## Seven-day services

- The Intensive Care Outreach Network (ICON) and Clinical Site Practitioners (CSP) are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours a day, seven days per week.
- There was 24 hours a day, seven days a week consultant cover on the critical care units.
- Allied health professionals such as physiotherapists were available seven days per week.

## Access to information

- Staff were positive about the electronic patient record system in use. They reported there were no delays in accessing patient information.
- We saw that all information needed to deliver effective care and treatment was available to relevant staff via the patient electronic record.
- When children were moved between teams and other hospital services, all the information needed for their on going care was shared appropriately, in a timely way and in line with relevant protocols.

## Consent

- Consent and parental responsibility training was provided. 66% of staff had completed this training, which was below the 95% target set by the trust.
- All staff we spoke with were aware of the trust's consent procedures, including Gillick competency among children.
- Mothers we spoke with told us that staff always explained what treatment they were planning to give to a child and gained consent.
- We were informed that for those parents who did not have the capacity to consent, staff contacted the trust's social work department which made arrangements to ensure the parents were supported and the child received appropriate treatment.

# Critical care

## Are critical care services caring?

Outstanding



Caring was fully embedded into practice on the critical care units. Staff were fully committed to delivering strong person centred care. Children and their families were treated with compassion, dignity and respect. Parents were very positive about the care their children received. They felt informed, involved and able to ask questions when they were unsure of what was happening to their child. Families and children were provided with emotional support from a range of professionals.

### Compassionate care

- Throughout our inspection we observed children and their families being treated with compassion, dignity and respect. For example we observed one of the critical care unit ward clerks dealing with a father of a newly admitted child in a polite and caring manner.
- Parents we spoke with told us that 'the nurses are caring and compassionate'. We observed a nurse caring for an unconscious child who was communicating directly with the child with sensitivity and compassion.
- The doctors we spoke with told us that there was an emphasis on privacy dignity and compassion on the unit and we witnessed both doctors and nurses practicing this at the bedside.
- The comments received in thank you cards on the unit praised staff, for example one stated 'thank you for saving my life'
- Doctors were observed to be polite with both children and their families taking time to explain information.
- Mothers we spoke with provided positive feedback about the care they and their child received and considered the care delivery to be excellent and safe. Many had completed the Friends and Family Test (FFT) and all said that they would recommend the unit to their friends and family.
- We noted that parents were able to provide feedback to the CATS team via social media. The CATS annual report 2013/2014 included many examples of positive feedback.

- The results of a compassionate care audit undertaken in 2014 and involving the staff on the critical care unit showed high levels of compassionate care awareness. An action plan had been developed to address areas for improvement identified.
- The critical care unit completed the department of health "You're welcome audit" which demonstrated that the team met the wishes of both young adults and their parents.

### Patient/families understanding and involvement

- Mothers we spoke with told us that staff kept them fully informed about their child's progress. They believe they were given excellent support and care, with nurses and doctors giving them clear and prompt explanations.
- Each child was allocated an individual named nurse and the parents we spoke with on the critical care unit told us that they felt confident with the care they received.
- We observed a family being prepared for transfer to another hospital by the CATS team and noted that the information provided before the child was transferred was clearly understood by the parents.
- Mothers we spoke with knew their named consultant. We observed nurses and doctors keeping parents up to date with their child's treatment plan
- There was an organ donation committee and specific policies in place. A specialist nurse for organ donation was available to support staff approaching relatives for organ donations when treatment was being withdrawn.

### Emotional support

- There was a clinical psychologist attached to the critical care unit who was available for all staff and parents and able to offer support. Mothers told us they could access this service by making an appointment.
- Families' needs were discussed at the weekly MDT meeting, attended by the clinical psychologist, chaplain and social worker.
- The chaplain service provided spiritual and emotional comfort to parents and relatives. The service was also available to staff to assist them understand some of the cultural aspects of care delivery within critical care.
- The nurses, doctors and parents we spoke with were supportive of the effectiveness of the family liaison nurses within the critical care units, which they considered to be essential when children were admitted.

# Critical care

## Are critical care services responsive?

Good



The flow of children through the critical care unit was managed effectively to avoid delayed discharges and manage capacity. The individual needs of the children were met. Parents were supported during and after discharge from the unit. They had access to parent accommodation in an adjacent building. There was a complaints policy and procedure in place, however, there were very few formal complaints made.

### Service planning and delivery to meet the needs of local people

- The unit provided critical care to children from all areas of the UK and overseas and did not serve a specific local population. However, there was a service user strategy that had been drafted following engagement with 2500 patients, families and staff members, which informed service planning.
- The critical care facilities were purpose build and designed to ensure that they were appropriate for the services delivered.
- The unit utilised bank staff from their own nursing establishment to cover during busy periods and respond to fluctuations in workload.
- The unit had parents' sitting rooms and kitchenettes, which were available on all critical care units. There was provision for tea and coffee making and microwaves were available.
- Children requiring home ventilation care and ventilation weaning were managed through a dedicated group of staff on the transitional care unit. All parents were given a ward based competency book to complete to help them develop the skills they need prior to discharge home.

### Meeting people's individual needs

- The hospital had developed a pocket-sized guide to help staff working with children with learning disabilities. This contained prompts to remind staff that this group of children have special needs. The nurses we spoke with found this to be helpful when caring for children with these disabilities.

- All children admitted to the critical care unit had an individual treatment plan developed by the child's intensivists. We noted these were included in the child's records and regularly updated.
- Staff were able to access interpreters either in person or via telephone for families who did not speak English.
- Staff we spoke with demonstrated that they were aware of the on-going care needs of children with complex needs and mindful of an individual child's long term care.
- The CATS team stated that parents were able to travel in the ambulance or helicopter with their baby during transfer into the unit.
- Parents of children admitted as an emergency were provided with a snack pack and personal hygiene pack, including fresh water, toothpaste, shampoo and conditioner.
- Breast feeding mothers received a daily food voucher to use in the hospital restaurant.
- There were facilities for mothers who were expressing their milk. These were in individual rooms and the breast milk pumps were noted to be as specified by national guidance. Mothers staying in the parent's accommodation were given breast pumps in their room to avoid the need of the mother having to return to the unit to express her milk.
- A visitor's waiting area providing families and relatives with an area to take a break away from the bedside. There was an identified parent's room on the unit which was used by medical and nursing staff to speak to parents privately.
- For those parents of children who had died on the unit there was a bereavement room, with sleeping facilities and suitable provision to allow these parents to spend time with their deceased child.
- The hospital's website had a range of information about critical care for parents, children and staff. This was provided in a range of formats including written, audio and moving image information.
- Feedback was actively sought from parents. We noted post boxes and 'we value your opinion' posters in every room that parents had access to on the units.
- The units had family interview rooms that were used to speak to parents in confidence including when the need arose to break bad news.

### Access and flow

# Critical care

- The bed management policy provided guidance on how patients would be prioritised in times of extreme pressure. This stated that those patients ready for transfer from the critical care unit to ward areas would be given priority. The bed management team were responsible for monitoring bed capacity, which was discussed at the daily operational bed meeting at 9.30am and 4pm, Monday – Friday.
- The Intensive Care Outreach Network (ICON) and Clinical Site Practitioners (CSP) are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours a day, seven days per week. They arranged the admission of these children to the critical care unit as required.
- All admissions, both internal and external referrals, were discussed with the consultant in charge and the referring doctor to ensure the unit was the most appropriate place for the child to be.
- Transfers out of the unit to the wards and HDU areas were monitored by the CSP team and the ICON team for 48 hours post transfer to ensure any deterioration was identified in a timely manner.
- The bed occupancy for critical care was reported to be 86.5% each month between August 2013 and November 2014. This was higher than the England average of 79.6% over the same period.
- In the previous 12 months there were 794 unplanned admissions to the critical care unit. Of these, 712 children were transferred into the units from other hospitals. This is higher than other paediatric critical care units.
- The majority of admissions to the cardiac intensive care unit were planned admissions with 61% from other hospitals.
- A mother we spoke with told us she had made a complaint about her child's care in the older part of the hospital to PALS. This had been escalated and she had received an apology.
- The complaints team co-ordinated the response to any complaint with the input from the unit.
- Staff we spoke with confirmed that lessons from complaints were cascaded and discussed at ward meetings and provided examples of how the service had learnt from complaints.

## Are critical care services well-led?

Requires improvement



The critical care division had a vision for the development of the service but nursing staff considered this to be primarily medically led and failed to reflect the contribution of nursing. There were identified leadership arrangements and staff felt supported and able to raise concerns. However, there were some unresolved tensions between senior medical and nursing staff. Some risks had been on the risk register for over three years and minutes of the monthly critical care board did not demonstrate progress on resolving them.

### Vision and strategy for this service

- There was a vision and strategy for the service in the form of an annual divisional plan that documented the objectives of the service. Progress against these objectives was reported via the performance review framework. The staff we spoke with were aware of the service priorities for the unit and these had been discussed in ward meetings.
- Many of the nurses we spoke with felt that the medical staff vision of becoming the world's premier children's hospital was failing to reflect the contribution of nursing in this vision.
- Consultants we spoke with stated that the new CEO had a clear vision for the future direction of the trust including the critical care units.
- The trust's mission and core values were displayed on a variety of posters throughout the hospital and on all screen savers on the unit's computers.

### Governance, risk management and quality management

### Learning from complaints and concerns

- Parent representatives were invited to the weekly critical care unit meetings and to the monthly critical care division meetings to promote transparency and to obtain feedback on family satisfaction with service delivery.
- The PALS manager reported that the service received 1000 enquiries quarterly with 50% being related to information. Of the remaining 500, 80% were low level with 20% complaints.



# Critical care

- The critical care division had a documented governance structure that identified the reporting arrangements for individual groups and meetings.
- The critical care manager stated that monthly risk meetings took place. The minutes of these meetings that we saw demonstrated that they were attended by all grades of staff and topics discussed included a review of learning from incidents.
- The critical care services risk reports were presented at the risk action group and cascaded to all critical care staff and included for example the findings of the “You’re welcomed audit”.
- The monthly critical care board attended by the senior managers of the unit discussed a range of issues including quality and safety. The minutes for the September 2014 meeting showed that actions to address issues raised were identified and assigned to individuals to respond to. However, the minutes were brief and did not demonstrate progress on previous action and therefore it was not possible to assess the effectiveness of this group in completing actions.
- There was a critical care risk register. Staff we spoke with were aware how to escalate risks onto this register. We noted the register included risks such as medication administration errors, and identified actions to be taken to mitigate the risks. The date the risk was entered on the register was recorded as well as when it had been reviewed. Some risks had been on the risk register for over three years such as results not on the electronic flow sheet without being resolved.

## Leadership of service

- Many staff stated senior nursing staff were visible and approachable, supporting staff, ensuring issues were addressed in a timely manner. While others did not feel senior managers listened to them when raising concerns.
- Many of the nursing and medical staff we spoke with reported tangible difficulties in communication between senior nurses and senior medical staff and this relationship was strained. Some of the senior nursing staff said they felt undervalued.

- There was a supernumerary clinical coordinator on duty 24 hours a day, seven days a week in all critical care areas to provide leadership and support.







## Culture within the service

- The critical care units had an open, caring and supportive approach. Care was delivered as a team effort and there was effective team working.
- The staff we spoke with were positive about the quality of care that they gave to children and were all highly supportive of the trust’s mission statement
- We were informed that there were effective relationships between junior nursing and medical staff across the three units of the critical care service. However, some nursing staff reported poor communication between doctors and nurses and between the three units, which make up critical care.
- There was child and family centred culture on the units based around the trust’s mission statement of the child first and always.

## Public and staff engagement

- Staff we spoke with had attended the chief executive open forum meetings, at which the future vision and strategy for the trust was shared.
- Staff reported that email was used as the main form of communication with briefings and newsletters sent via this medium.
- Parent engagement was at the weekly unit meetings with family representation being sought for the larger full monthly critical care meetings.
- The staff we spoke with considered that they were actively engaged in the planning and delivery of services and in shaping the culture of the trust. However, some senior nurses felt the nursing contribution to future care was given less attention than to that given to medical care.

# Neonatal services

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

## Information about the service

The neonatal intensive care unit (NICU) which is part of the Critical Care Division at GOSH treats approximately 500 patients per year. As there are no obstetric facilities within GOSH it is not a traditional NICU. The Neonatal Intensive Care Unit (NICU) has 10 cots configured in an open plan area. It is located on Level 4 of the Variety Club Building (VCB). In addition there are 6 cubicles providing isolation facilities.

The NICU primarily admits general surgical neonates, who are often preterm and are referred from other hospitals. The unit often treats neonates with necrotising enterocolitis, bowel obstruction, oesophageal atresia, tracheoesophageal fistulae and other congenital anomalies. Additionally neonates with complex medical and surgical problems from other specialties are also admitted. There is extensive research by both surgical and medical teams into the causes and treatments for necrotising enterocolitis in neonates.

NICU also admits neonates brought to GOSH who may need extracorporeal life support (ECLS, also known as ECMO). Two of the consultants have a specialist research interest in persistent pulmonary hypertension of the newborn. The NICU is part of the North Thames Central Neonatal Network and the the British Association of Perinatal Medicine. In this collaboration, it aims to provide optimum services for neonates by sharing practice and service opportunities with other hospitals. This unit provides care for critically ill newborn babies and infants

who need the highest level of nursing and medical care with the majority needing surgery for various problems. Babies requiring intensive care in NICU receive one-to-one nursing care.

We spoke with, 3 parents and 9 staff members including, nurses, doctors, consultants, and a senior manager. Additionally we also observed and spoke with members of the CATS team in the process of preparing a baby for transfer. During the inspection we examined the care and treatment of babies and we also reviewed care records. Before and during our inspection we reviewed performance information from, and about, the trust.



# Neonatal services

## Summary of findings

The NICU at GOSH had very good systems and processes in place to protect babies from abuse and avoidable harm and these included reporting and learning from incidents. Nurse staffing levels were in line with national guidance and staff had access to a range of training both internally via the GOSH education department and at local universities. The needs of the babies and their mothers or carers were met by skilled and experienced staff including breast-feeding experts. The staff members were accustomed to caring for babies with co-morbidities. Policies were based on NICE and other relevant national guidelines. NICU shares data with the British Association of Perinatal Medicine. There was a formal escalation process in place for managing deteriorating babies and out with NICU in the high dependency unit care staff have been trained in its use and knew how to effectively use the responsive clinical site practitioner team and the hospital at night team.

The capacity and flow of babies through the NICU was managed by collaborative working with other providers across London and further afield. The team of senior medical team co-ordinated the Intensive Care Outreach Network (ICON) which worked closely with the clinical site practitioner team. Nursing staff felt supported by the senior nursing team and were able to raise concerns without fear of retribution. The staff members we spoke with were fully aware of the new chief executive and his plans for the future direction of the Trust. Interprofessional working was fully embedded within the NICU.

## Are neonatal services safe?

Good



The NICU had robust systems and process in place to protect babies from harm, these included reporting and learning from incidents. Staff understood their roles and responsibilities in relation to safeguarding babies and how they worked with other agencies to promote the infants best interest. Nurse staffing levels were in line with national guidance from the Royal College of Nursing and the British Association of Perinatal Medicine (BAPM), with the ratio of registered nurse to infants at 1:1

The staff had access to a range of training, both internally and at local universities and all nurses in NICU were given the opportunity to progress through an orientation and development programme. There was ongoing band 5 and band 6 development and for some senior band 6 nurses there was the opportunity for some of them to attend a leadership programme as preparation for progressing to band 7 positions. There was a formal escalation process for managing deteriorating babies in high dependency complemented by a robust and effective clinical site practitioner team, hospital at night team and the Intensive Care Outreach Network service. The Trust had implemented the children's early warning score system (CEWS) and the use of the Situation – Background – Assessment – Recommendation – Decision (SBARD) communication tool to identify, record and report signs of deterioration in infants. The staff within NICU had been involved in a large range of quality monitoring and clinical research. The staff on NICU also had a strong support network for families and there were regular midwife clinics, family liaison nurses, psychological support and breast-feeding specialist available.

### Incidents

- Staff we spoke with told us that they used an electronic incident reporting system and that incident reporting was high. They said there was a transparent culture of reporting all incidents including those considered minor.
- We saw evidence that 268 incidents were reported across the whole of the critical care unit between October 2014 and January 2015

# Neonatal services

- All medical and nursing staff we spoke to were aware of how the actions to take when an incident occurred, these included reminders being sent by email to all staff, individual involved in incident being asked to complete a diary tool to analyse and reflect on the incident.
- The May 2015 board minutes showed that there had been no reports of unsafely staffed shifts in the previous two months.
- The housekeeper we spoke with stated that she had received training on the use of the incident reporting system and was aware of how to report incidents. She cited an example of an incident she had recently reported and told us that she had received an email confirming that the incident had been logged.
- Following incident investigations, the findings and learning were cascaded to all staff through a range of different methods. These included, for serious incidents, a one-page summary and root cause analysis report, patient safety messages issued on a weekly and monthly basis and internal patient safety alerts circulated for issues of particular concern.
- Changes to practice following incidents are cascaded to staff members via emailed safety reports. We were able to inspect a range of paper copies of these emailed safety reports which gave significant details of the incident and the subsequent learning. The Trust governance team is responsible for cascading these post incident safety reports. We witnessed the early morning nursing handover in NICU where all incidents and care management strategies discussed. At this meeting progress for implementing changes post incidents were reviewed to ensure full compliance. This process for the
- There had been no never events or serious incidents requiring investigation reported for the NICU service at this Trust. We were told by the head of clinical governance the mechanisms for responding to clinical incidents and the serious incident investigation reports we saw demonstrated that recommendations had been made and further discussed at the weekly mortality and morbidity meetings held across the whole of the critical care division
- The quality assurance strategy is published each year and the 2014/15 report we examined had a mission statement to reduce all harm to zero. For example central venous catheter line infection has decreased from four per 1,000 line days in 2012/13 to two per 1,000 line days in 2013/14 reduced to 1.4 in 2014/2015
- There were weekly multidisciplinary mortality and morbidity meetings within NICU at which all incidents were discussed. In addition we observed that this meeting also discussed standing agenda items such as hospital acquired infection, reoperations, transfers from other centres and readmissions All mortalities occurring within the unit were discussed in detail. The minutes and output from these meetings are referred back to the trust Clinical Governance committee.
- All staff we spoke with told us that they were aware of their responsibility in relation to the duty of candour.

## Safety monitoring

- Data is collected each month in NICU for all new cases of jaundice and the auditing of how neonatal jaundice is managed will continue as part of the Trust priority clinical audit plan, to ensure that improved practice is maintained and awareness of neonatal jaundice remains high.
- Work was undertaken with staff on the Paediatric Intensive Care Unit (PICU) and NICU to ensure effective communication within the wards and to the wider hospital to improve patient flow into and out of PICU and NICU.
- The DH high impact intervention number 7 related to the care bundle to reduce the risk from *Clostridium difficile* was monitored in NICU in 2011/12, the Trust reported a total of eight cases of *Clostridium difficile* against an agreed trajectory of nine.
- For the NICU the focus had been on an increase in situational awareness, with babies estimated discharge dates displayed on a Patient Status at a Glance electronic whiteboard. These dates were reviewed twice a day at ward round
- Within the neonatal unit staff use an adapted skin integrity assessment tool which is part of the electronic patient record which is checked 1 - 4hrly and the staff were committed to improving skin viability in vulnerable babies. Incident forms are completed for any baby with skin deterioration. We were told that there had been no reports of skin problems developing during admission to NICU within the previous year and confirmed by the 2013/14 annual report.
- Endotracheal tubes (ETT) and ventilation circuits were currently being audited to identify any possible adverse

# Neonatal services

outcomes. We examined a range of patient records to confirm monitoring of ET tube length within the NICU which was consequential upon a previous incident caused by ET tube movement.

- To determine Ventilator Associated Pneumonia we examined the GOSH 2014 Annual Infection Prevention and Control Report to assess post intubation respiratory infection (including ventilator associated infection). We noted that GOSH had reported a Ventilator Associated Pneumonia (VAP) study which was a four month prospective, nurse-led surveillance study on Ventilator Associated Pneumonia (VAP) investigation. Subsequent to this study the saving lives care bundle was adapted for implementation on NICU and surveillance demonstrated reduction in VAP by the criteria used.

## Cleanliness, infection control and hygiene

- The NICU was visibly clean with dedicated cleaning staff provided by an external company. Staff we spoke with told us the cleaning staff were responsive. We observed cleaning requests made by nursing staff were responded to in a timely manner.
- The NICU performance dashboard included infection rates.
- Parents we spoke with told us that the nursing staff had shown them how to wash their hands before contact with their children to avoid cross infection. They also told us that the doctors and nurses frequently washed their hands.
- We observed that doctors and nurses washed their hands before delivering care and used the hand sanitizers frequently.
- Throughout the unit we noted visible wall mounted notices promoting hand sanitation.
- We were informed by the practice educators we interviewed that Infection control training was part of mandatory training that all staff were expected to complete. This was confirmed other staff we spoke to. Training data seen for NICU showed that 100% of ancillary staff had completed this training and 83% of nursing staff
- We saw a housekeeping task sheet, completed daily by the house keeper, listing tasks to ensure that NICU was tidy at all times. We examined the published code of conduct for health care support workers at GOSH which emphasised the importance of all team members working together effectively.

- There were appropriate numbers of hand washing sinks in the NICU including a non-touch dual hand washing sink located at the entrance to the critical care area for staff and visitors to use before entering NICU.
- Nurses were responsible for cleaning equipment around the incubators daily, and we saw that this was recorded on the electronic recording system.
- Following an infant's discharge from NICU the incubator was taken to a cleaning room in the basement of the hospital for cleaning to prevent cross infection.
- The trust wide infection control policy included guidance on caring for children in incubators.
- The consultant microbiologist undertakes a ward round on the NICU twice a week to review microbiology results and infection control requirements. The IPC team and on call microbiology service are available 24 hours a day for advice on whether a child or young person should be isolated.
- The NICU reported in its 2013/14 annual infection control report that there were 9 episodes of venous catheter-related bloodstream infection with 1450 line days with 2.8 infections per 1000 line days.
- The unit had an identified infection prevention and control link nurse, All staff have been trained in hand hygiene and every month, the link nurse through the governance of the Infection Prevention and Control (IPC) team audits compliance to the hand hygiene protocol.
- The results of the infection control audits were displayed for the public in the corridors and on the NICU dashboard. The 2014 published Infection Prevention and Control Annual Report shows that compliance rates for hand hygiene have increased but are still not at 100%, across all clinical areas
- All staff we saw during our inspection of NICU adhered to the bare below the elbows policy, as well as utilising appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities.

## Environment and equipment

- Entry to the NICU was via keypad entry with CCTV coverage to allow staff to observe for "tailgater entry"
- All equipment was checked and cleaned before being returned to the hospital departments by the electro bio-medical engineering department [EBME].

# Neonatal services

- The hospital had an asset management system which utilised radio frequency (RFID) identification to track equipment loaned from the asset library. This system had a built in warning system to alert engineers when RFID batteries were within two months of expiry.
- When equipment was returned to the library the RFID system alerted engineers within the EBME department that it was available for scheduled maintenance.
- The resuscitation trolley on NICU was checked daily. We inspected the checking records and ascertained that it had been appropriately checked and replenished as required.

## Medicines

- There was a hospital wide medication policy and staff we spoke with were aware of policies pertinent to the administration of medicines to babies.
- The unit had a designated pharmacist who told us prescribing procedures are satisfactory. To substantiate this we examined a range of antibiotic prescription charts and these were prescribed correctly.
- Senior nurses confirmed that medication storage was safe and we inspected the medication dispensing cabinets in the NICU and noted that storage was safe in terms of access.
- The pharmacist attends the NICU daily (Monday-Friday) to review babies medications to ensure that they were suitable and within prescribing guidelines.
- Medication audits are undertaken through the Electronic Prescribing and Medicines Administration (EPMA) system.
- We noted that drug fridges were locked and daily temperature checks were completed and records kept of these checks.
- Specialist parenteral nutrition intravenous fluids were stored in a special drug refrigerator on NICU.

## Records

- Patient records on NICU were recorded electronically on a central data base.
- We found that the sample of care records we reviewed was compliant with national standards (Nursing and Midwifery Council for example). The quality of written and electronic records we examined on NICU was fully compliant with these standards.
- The nursing records we reviewed included individual care delivery plans, and a summary of care delivered as well as a record of the infants observations.

- Staff reported that the multiplicity of the hospital's IT systems was time consuming. In some cases, if an electronic patient record had not been closed down on an IT system by one staff member ( i.e. their access terminated), it was not able to be accessed by another professional.
- We examined 5 sets of patient's medical and nursing records and found that the quality of entries was compliant with contemporaneous entries which were legible, dated and signed with the designation of the staff member reviewing the infant's record.
- The 4 sets of medical records we examined provided a record of the plan of care and any investigation results.

## Safeguarding

- All medical and nursing staff we spoke with told us that they had been appropriately updated with regard to safeguarding.
- We were told and records held at unit level demonstrated that 100% of staff had completed safeguarding level one, 93% level 2 and 98% had completed level 3 safeguarding training.
- Staff were provided with a safeguarding children update on an annual basis. The housekeeper we spoke with stated she had received safeguarding updating and that she had been informed that she was required to attend this training via email.
- In line with national guidance, following the Saville Inquiry there was a policy and procedure in place for celebrity visitors. In these situations, a staff member acted as a chaperone for these visitors to ensure they were never left alone with patients. The nurses we spoke with were familiar with these procedures.
- There was a local (CAMHS) guideline for the management of absconding children.
- There was evidence from the nursing staff and medical staff that we interviewed that safeguarding processes were embedded in the whole culture of the NICU service and CATS.
- The senior medical staff we interviewed within NICU confirmed that they and their junior colleagues had completed Level 3 safeguarding training. Level 3 safeguarding training among medical intensivists staff was currently at 97%
- The training strategy is continually reviewed by GOSH Safeguarding Children Group which reports into the Clinical Governance Committee. The Trust has a

# Neonatal services

Safeguarding Team comprising: Named Doctor - 1 x two days a week (0.4 WTE), Named Nurse - 1 x full time post (1 WTE), Safeguarding nurse specialists - 2 x half time posts (0.5 WTE and 0.6 WTE), Administration support - 1 x full time post and 1 x half time post 0.7 WTE (1.7 WTE). The Chief Nurse is the Executive Director Lead for Safeguarding Children and Young People and chairs the Safeguarding Children Group which reports to the Board on safeguarding children via the clinical governance committee.

- The staff we spoke with were able to describe the process for reporting any concerns to social services and were fully conversant with the procedures necessary when a safeguarding issue was raised.
- For children at GOSH for longer periods, after 3 months, the child's local authority was informed and asked to assess the child and family's additional needs.

## Mandatory training

- The trust has identified 28 mandatory training modules that staff were expected to complete including safeguarding and resuscitation. The level of training was dependent to the individual staff members role but there was a 95% completion target set for all modules,
- There were designated practice education facilitators (PEF's) attached to NICU and they maintained a record of the mandatory training completed by staff.
- There was a range of topics that were considered mandatory for qualified nurses, these included medicines management training and pain pumps management. The training records showed that for some course such as pain pumps management, only 60% of critical care staff overall had completed this training which was below the 95% target. For the same courses we were told that 100% of NICU staff had completed the training.
- The nurses we spoke with stated it was difficult to make time to complete mandatory e-learning modules.
- All nurses we spoke with said they had completed induction training on commencement of employment, and this is detailed within the GOSDH NICU web pages.
- The staff we interviewed informed us that they were sent advance email correspondence reminding them of scheduled mandatory training updates.
- NICU had a structured development package and career pathway for nurses which included including advanced life support courses. There were also opportunities for

neonatal nurses to undertake a neonatal intensive care course. We noted very advanced systems in place for ensuring nursing and medical mandatory training within NICU with time allocated to do so. We inspected several training records which were clear and up to date. We noted that there was a well monitored system for ensuring that NLS - Newborn Life Support and Advanced Resuscitation of the Newborn Infant (ARNI) course training.

## Assessing and responding to patient risk

- In monitoring babies for signs of deterioration the unit used a one to one nurse to patient ratio and a low doctor to patient ratio. The ICU does not use CEWS; however CEWS are used on the HDU and other wards across GOSH.
- We observed that vital signs were frequently recorded for sick babies with NICU to identify signs of deterioration.
- Throughout the NICU the electronic patient data board was displayed showing a range of clinical information and staff we spoke with stated they found these to be helpful in overall patient management.
- The clinical site practitioners (CSP) provide the outreach service to the wards, 24 hours a day, seven days a week, assessing and responding to deteriorating babies outside the NICU. They also lead the resuscitation team in the event of a patient collapse.
- We noted the CSPs used the Situation, Background, Assessment, Recommendation, and Decision (SBARD) communication tool when discussing babies who may be deteriorating on the ward to elicit information on which to base clinical decisions. We were told all staff knew how to use these proformas for the CSP consultation. We observed such an assessment of a neonate who had been flagged for monitoring in the high dependency unit.
- The CSP team also provided ward staff with telephone advice and any baby in which there were concerns about deterioration were flagged by the team and seen during the regular CSP rounds. We observed that during the CSP round babies were assessed and staff provided with advice or if appropriate transferred to a critical care unit following discussions with the critical care intensivists.



# Neonatal services

- We were informed by the recently appointed neonatal consultant that new policies had been developed to ensure that babies in HDU were monitored to detect any deterioration which might necessitate transfer to critical care.
- We observed that on the neonatal unit electronic listening ears were used to prevent noise pollution by alerting staff to maintain quietness.
- All children on the NICU were assessed using the child safety thermometer and SBARD as required.
- The clinical site practitioner team, the ICON team and the hospital at night team have developed a responsive mode of operation to effectively manage and escalate as necessary concerns related to patient deterioration.

## Nurse staffing

- Nurse we spoke with said there was sufficient staff to meet the needs of the babies. The staff rotas we examined showed the numbers of staff scheduled to be on duty and the roster system was updated with the actual names and numbers required to meet the planned activity. These met the national staffing guidance provided by the Royal College of Nursing.
- We saw that all babies' children received 1:1 registered nurse support.
- The majority of parents we spoke with told us that they were confident that there were enough doctors and nurses on duty at all times to care for their babies.
- There were some vacant band 6 nursing posts and we were told that there had been difficulties in recruiting to this grade. Sickness and vacancies were covered by the hospital's nursing bank. We noted that 80% of nursing bank staff used in the NICU were the unit's own staff working additional shifts and 20% were former employees.
- Neonatal nursing staff informed us that there was an internal movement of staff across all three of the critical care units to enable them to respond to skill mix challenges as necessary.
- We were informed by the critical care practice educators that all nursing staff working within NICU had completed advanced paediatric/neonatal life support training for paediatric or neonatal resuscitation. Nurses we subsequently interviewed were able to confirm this.
- Nursing staff were supported by health care assistants who had completed specific critical care competency

based training developed by the PEFs. In one case the health care assistant we interviewed was a trained overseas neonatal intensive care nurse awaiting registration in the UK.

- All NICU nurses worked 12 hour shifts and there were two nursing handovers daily at which all nurses were given a written print out of all the infants being cared for on the unit, which detailed the individual care plan.
- The head of nursing for critical care attends NICU nursing handovers and during an early morning handover on the neonatal unit we observed the head of nursing verify with the senior clinical nurse on duty that there were sufficient staff.
- The CSP held separate handovers twice daily with the hospital at night team to ensure all staff were aware of children and babies outwith critical care who may have needed additional support.
- The neonatal unit's nursing establishment was currently 51.5 WTE and as of December 2014 45.6 WTE were in post.
- There was a designated supernumerary nurse in charge for every shift and any staff sickness and vacancies were covered by agency staff, which were usually the unit's own staff who wished to work additional hours.

## Medical staffing

- The multidisciplinary team on NICU was led by a team of eight consultants.
- Doctors we spoke with told us that medical cover met the needs of children. The night cover was orientated around the hospital at night team which included clinical site practitioners and rotational medical staff including the Intensive Care Outreach Network (ICON) and anaesthetists.
- The ICON was established in 2012 and consists of a dedicated consultant and six ICON/ICU fellows and aimed to provide a seamless link between the intensive care units, high dependency units and wards throughout the hospital. This service is fully integrated into the hospital at night and CSP service.
- There were two medical handovers every day.
- All middle grade doctors and consultants had completed the APLS course and if necessary had attended APLS update training.
- The Critical Care unit at GOSH has intensivist consultant cover at all times. The ICON service (Intensive care



# Neonatal services

outreach network) developed by the Critical Care Unit provides cover across the whole hospital at all times supported by the clinical site practitioner team and the hospital at night team.

- 8 consultants cover PICU beds in addition to 9 NICU beds. During week days there is separate consultant cover for the NICU.
- NICU has a 24 hour consultant led service.

## Major incident awareness and training

- There was a local emergency preparedness resilience policy in place.
- We were informed that winter and summer resilience management plans are fully operational to cope with for example seasonal variations in morbidity within the childhood population.
- Plans are in place for a wide range of issues such as the loss of utilities, loss of staff, communications, IT and the emergency call system. In the event the unit needed to be evacuated alternative locations had been identified as suitable to accommodate level 2/3 patients. This plan was put into operation during the fire which broke out in the cardiac wing in 2008 where 40 children, some unconscious were successfully evacuated.

## Are neonatal services effective?

Good



Policies used within NICU were based on NICE and other relevant guidelines.

They were regularly reviewed and updated to ensure they reflected any changes in practice. A wide range of clinical audits and research was being conducted within the unit. The use of care bundles is embedded and patient outcome data pertinent to NICU has been reported in medical evidence based practice journals.

There was a structured induction and development programme for all staff and staff had the skills and experience to deliver effective care to babies. Care was delivered by a cohesive multidisciplinary team who utilised their individual skills and knowledge. Cover was provided over seven days to meet the needs of the patients and allied health professionals were available seven days per week as requested.

## Evidence-based care and treatment

- Policies and care bundles used in NICU critical care were based on NICE and Royal College guidelines. Adherence to NICE protocols was noted within the Trust annual reports
- All staff we spoke with confirmed that they had easy access via the trust intranet to policies and procedures. We accessed the data base of policies and procedures via the NICU computer to review the NICU pain protocols.
- We were told and observed that medical staff could access trust protocols via their mobile phones which provided them with instant access to the protocol data base.
- There was an annual audit plan that included a range of audits including patient outcome audits. Each audit had a start and end date as well as an identified lead clinician.
- Policies in NICU were regularly reviewed to ensure they were based on contemporary NICE guidelines.
- Medical staff working in NICU keep up to date through the British Association of Perinatal Medicine. A variety of mechanisms including information elicited from the Paediatric Intensive Care Audit Network monthly newsletters was also used.
- The NICU service ensure adherence to local best practice guidelines through a variety of activities ranging from regular staff meetings through to direct education provided by the critical care clinical nurse education facilitators
- The NICU service ensures compliance with critical care bundles and one of the consultants within the critical care had published a scholarly paper within the journal "Current Opinion in Infectious Diseases" entitled "Using Care bundles to prevent infection in neonatal and paediatric ICUs"

## Pain relief

- The Trust has a trust wide pain team and this is explained to parents via a comprehensive page on the Trust website. The team is consultant led and is a multidisciplinary in nature with 6 clinical nurse specialists among the membership. The service sees 2,500 children per year
- The pain team liaise directly with the NICU through the pain link nurse.

# Neonatal services

- Patient's pain is assessed and managed in conjunction with the GOSH pain team.

## Nutrition and hydration

- Staff told us that nutrition and hydration needs were fully met within the NICU. For example babies within the neonatal unit were able to access freshly expressed breast milk. We examined the milk kitchen and it conformed to national standards.
- There was a paediatric dietician who undertook weekly ward rounds on the critical care unit to ascertain that any potential problems with nutrition are fully addressed.
- We observed that infant feeds were readily available and stored at the correct temperature in the neonatal areas.
- Infants' nutrition and hydration needs were assessed and met through the use of a range of clinical guidelines e.g. Infant feeding guideline
- We noted that records were kept of intravenous infusions and parenteral nutrition and the child's fluid balance, enabling staff to monitor the infant's nutrition and hydration status.
- Breast feeding mother had access to a breastfeeding specialist nurse and mother with babies with special feeding needs were able to be referred to the dietician.

## Patient outcomes

- The neonatal unit is primarily a specialist surgical unit and is not linked to the neonatal data base Badger, therefore the performance of the unit is not measured against other neonatal units nationally. However NICU is part of the North Central and East London Neonatal Operational Delivery Network (ODN) where data is shared
- We saw that the electronic patient data boards were effective in giving professionals up to date patient information such as name, hospital number, and bed number. When a baby is ready for discharge the colour of the entry changes, and it also displays the number of days the baby waits for a discharge cot as required.
- The CSP team had undertaken benchmarking with an adjacent London children's hospital who offer a similar service. This exercise found that the GOSH service continues to fulfil its primary role in managing deteriorating infants.

- The clinical assistant and patient pathway manager assisted medical trainees in teaching them how to use the data systems, both paper and electronic, to monitor infant outcomes on the NICU. This has improved access to the data systems.
- Care bundles which are a group of three to five evidence based interventions, which when performed together have better outcomes for the patient, were used in NICU to promote the delivery of the best possible care for critically ill babies. Such application has for example, reduced the rates of infection within this vulnerable groups of babies.
- The NICU which is part of the critical care unit is one of 6 research hubs within GOSH. The unit has been involved in a full range of national and international research including examining the effect of cooling in babies with necrotizing enterocolitis (NEC) and because neonatal sepsis is a major cause of death and complications despite antibiotic treatment, the use of immunoglobulin in neonatal sepsis in preterm infants INIS (Immunoglobulin in Neonatal Sepsis)
- The service is regularly reviewed to ensure the effectiveness of care and treatment through local audit as in newborn blood spot screening and nationally as in for example participating in a national audit of cleft lip and palate, which is being managed by the South West Cleft Team in Bristol.
- We inspected the minutes of the meeting of the GOSH Trust Board dated Wednesday 25th March 2015 which provided evidence that action plans were developed to address deviations from national targets.
- Information about the outcomes of babies care and treatment was routinely collected and monitored via North Central and East London Neonatal Operational Delivery Network.
- Many members of the nursing and medical staff are involved in activities to monitor and improve people's outcomes, for example the clinical professor of children's and young people's cancer care leads the GOSH centre for nursing and allied health research and evidence based practice.

## Competent staff

- Staff we spoke with on the NICU told us that professional development opportunities were available and

# Neonatal services

that they were supported to attend training courses such as London Southbank University advanced neonatal nursing courses which were funded by the trust.

- The practice education nurse facilitators (PEF's) were supernumerary and supported nurses at the bedside to develop their clinical skills.
- We were told that all unit managers had completed appropriate intensive care training and held intensive care qualifications.
- All NICU staff we interviewed told us that they had participated in an annual appraisal. The data provided by the trust showed that 68% of care staff had participated in an appraisal.
- Staff could apply for funding for professional development such as for specific modules or masters programmes, but obtaining funding could be challenging.
- The consultants we spoke with said that clinical supervision was provided for medical staff and this was confirmed by the junior medical staff we interviewed.
- We were told that the majority of health care assistants on the units were overseas registered nurses who were waiting to complete a university course which would lead to them obtaining their UK registration. The HCA we spoke with was an overseas nurse waiting to complete this course.
- All staff we spoke with stated they had the skills and experience to deliver effective care to babies predicated on their intensive care training primarily sourced from London Southbank University.
- To increase the skills of ward nurses in the management of transferred neonates from the NICU the CSP team delivered bedside teaching when called to see a baby in any part of the hospital. This ensured that staff felt confident to deliver specific care to sick babies.
- All staff had access to simulation-training sessions where infant manikins were available for resuscitation practice.
- There was a mentorship programme in place for NICU nurses organised by the PEF for the supervision of undergraduate child field of practice student nurses on placement. This was to ensure that this group of students were enabled to develop the skills required to care for sick neonates.

- We were told that NICU meets the Royal College of Nursing standards for staffing with 70 per cent of nurses holding a post-registration neonatal nursing qualification
- Staff appointed to the NICU had the right qualifications, skills, knowledge and experience to do their job when they started their employment, and to take on new responsibilities. Some of the health care support workers were overseas registered nurses with neonatal care experience.
- The learning needs of staff were identified at annual appraisal and in the case of the nursing staff monitored by the practice education facilitators who were able to liaise directly with local universities to access training courses and specific modules.
- All staff working on NICU were supported and managed through the annual appraisal system which identified personal training needs and professional accreditation such as revalidation. Poor or variable staff performance was identified and managed through appraisal where targets were set and monitored.

## Multidisciplinary working (MDT)

- All staff we interviewed on NICU told us that MDT working was effective. For example a senior physiotherapist told us that she had excellent working relationships with doctors and nurses on NICU. Furthermore we observed this effective MDT working when observing the dialogue between the CSPs and medical staff during our unannounced visit to the high dependency unit where babies who had been discharged from NICU were being cared for.
- We noted that bi-monthly meetings chaired by a psychologist took place to promote MDT working; these were embedded as part of the unit procedures.
- The CATS team members we spoke with described a MDT approach to patient care and transport. We observed this MDT working during our inspection of the NICU where a baby was being prepared by the CATS team for transport to another hospital.
- There were daily MDT consultant intensivist led ward rounds with input from nursing staff.
- We observed that the multi-disciplinary ward rounds were an effective method of delivering integrated care.
- We noted that staff within the NICU worked together to assess and plan ongoing care and treatment in a timely way when babies were moved between teams or

# Neonatal services

services. For example all babies transferred from the NICU to high dependency care were monitored for 48 hours post transfer by members of the clinical site practitioner team.

- When children are transferred from NICU to another hospital this was coordinated through CATS
- We saw several examples within the records on NICU which showed that on admission to the unit all babies had a treatment plan which was formulated by one of the consultants.
- We noted that all babies admitted to the NICU were clinically assessed to determine their risk of developing physical and non-physical morbidities including pressure ulcers.
- We saw good procedures for transferring recovering babies to the high dependency unit where they were monitored by the clinical site practitioners.
- There was a published discharge protocol guideline for transfer to another ward from the NICU.

## Seven-day services

- The Intensive Care Outreach Network (ICON) and Clinical Site Practitioners (CSP) are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours a day, seven days per week.
- There was 24 hours a day, seven days a week consultant cover on the NICU.
- Allied health professionals such as physiotherapists were available seven days per week.
- Daily pharmacy support (Monday - Friday) was available throughout the whole of critical care.

## Access to information

- Staff were positive about the electronic patient record system in use. They reported there were no delays in accessing patient information.
- We saw that all the information needed to deliver effective care and treatment was available to relevant staff via the patient electronic record. Additionally we noted that the e prescribing system worked alongside the wireless ward based mobile computers
- We saw that when babies were moved between teams and other hospital services, all the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols.

## Consent

- Consent and parental responsibility training was provided, 66% of staff had completed this training, this was below the 95% target set by the trust.
- All staff we spoke with on NICU were aware of the trust's consent procedures.
- Mothers we spoke with on NICU told us that staff always explained what they were going to do to their baby and gained consent as appropriate.
- The NICU had a published sedation policy based on NICE guidance.
- The staff we interviewed told us that the hospital had a robust social work department who were able to put arrangements in place if parents are not thought capable of providing consent.

## Are neonatal services caring?

**Outstanding**



Infants and their families were always treated with compassion, dignity and respect. Parents we spoke with were very positive about the exemplary care their babies had received. They felt very informed, involved and able to ask questions at any time when they were unsure of what was happening to their baby. Family members were always provided with emotional support from the whole interprofessional team to enable them to cope with their infant's treatment and any long term care needs. Caring was fully embedded in practice on the NICU with a tangible team spirit approach in which the GOSH mission statement of "the child first and always" was fully put into practice. Babies and their families were invited back to NICU on the eve of their first birthday to celebrate their recovery.

## Compassionate care

- Throughout our inspection we observed babies and their families being treated with compassion, dignity and respect. We witnessed many examples of the interaction between staff and parents which was always undertaken with politeness, caring and dignity.
- Parents we spoke with told us that 'the nurses were caring and compassionate' and we observed the CATS team preparing a mother and baby for transfer which was undertaken with professionalism and caring.

# Neonatal services

- The doctors and nurses we spoke to told us that there was an emphasis on privacy dignity and compassion with on NICU and we witnessed this when mothers were preparing to express their breast milk.
- The comments received in thank you cards on the NICU praised staff, for example one simply stating “thank you for saving my life”.
- Doctors were observed to be polite with families taking time to explain and give information in a manner parents could understand.
- The mothers we spoke with provided positive feedback about the care they and their child babies received and they told us that they considered the care delivery to be excellent and safe.
- We noted that parents were able to provide feedback to the CATS team via social media. The 2014 CATS annual report cites many examples of such positive feedback.
- Feedback was actively sought from parents we noted post boxes and "we value your opinion posters" in every room that parents have access to on the unit.
- We observed that that staff ensured that people's privacy and dignity was always respected, especially when delivering physical or intimate care to babies.
- We observed that when babies were experiencing any discomfort that the nurses and doctors responded in a compassionate, timely and appropriate way and the mothers we spoke with all confirmed this.
- We observed that staff respected confidentiality at all times in NICU.
- The results of a compassionate care audit undertaken in 2014 and involving the staff on the NICU showed high levels of compassionate care awareness. An action plan had been developed to address areas for improvement
- We observed a family being prepared for transfer to another hospital by the CATS team and noted that the information provided before the child was transferred was clearly understood by the parents.
- Mothers we spoke to knew their named consultant.
- We examined the range of information available to parents with on-going needs either via the hospital website, or via NICU based leaflets. Nurses we spoke with confirmed that they had access to this information to help them prepare families for on-going family centred care delivery within the home environment.
- We observed nurses and doctors keeping parents up to date with their babies treatment plans.
- We spoke to the head of PALs who showed us a full year data set (2014/15) which demonstrated how families who use services and those close to them were able to find further information or ask questions about their care and treatment.
- We observed staff within NICU communicating appropriately to families at all times.
- We noted that parents were involved in their babies care plans and when we approached them they were able to confirm that they had been kept fully in the picture of what was happening to their babies.

## Emotional support

### Patient/families understanding and involvement

- The mothers we spoke with told us that staff kept them fully informed about their child's progress. They believe they were given excellent support and care, with nurses and doctors giving them clear and prompt explanations.
- The CATS team told us that the parents were able to travel in the ambulance or helicopter with their baby during transfer into or outwith NICU.
- Each baby was allocated an individual named nurse and the parents we spoke with on the NICU unit told us that they feel confident with the care they received. We attended the early morning handover within NICU and witnessed the individual allocation of babies to individual nurses.
- We observed members of the PALS team supporting parents and giving them advice.
- There was a clinical psychologist attached to the NICU who was available for all staff and parents and able to offer support. Mothers told us they could access this service by making an appointment.
- Family's needs were discussed at the weekly MDT meeting, attended by the clinical psychologist, chaplain and social worker.
- The chaplain service provided spiritual and emotional comfort to parents and relatives. The service was also available to staff to assist them understand some of the cultural aspects of care delivery within critical care.
- The nurses, doctors and parents we spoke with were supportive of the effectiveness of the family liaison nurses within the NICU, which they considered to be an essential service.
- We observed parents being compassionately reassured during clinical procedures on their babies.
- We observed nursing staff engaging with and effectively communicating with parents of babies with complex conditions.



# Neonatal services

## Are neonatal services responsive?

Good



The flow of children through the NICU is managed to avoid delays in discharges and by working with other providers to effectively manage capacity. The Trust provides a well-established outreach service to the wards via the ICON and the clinical site practitioner teams. The needs of the babies were met in NICU and the unit had access to play specialists cover when needed for visiting siblings. Parents were well supported within the NICU and had access to parent accommodation in an adjacent building. There was specific comprehensive support for parents whose children are discharged with on-going care needs such as ventilator or tracheostomy support. The NICU had very few complaints.

### Service planning and delivery to meet the needs of local people

- The hospital as a specialist children's hospital taking children from all areas of the UK and overseas did not serve a specific local population. However, there was a service user strategy that commenced in 2014 with an engagement exercise involving 2500 patients, families and staff members. This strategy also involved service users in the GOSH research programme.
- The unit had parents' sitting rooms and kitchenettes, which were available on all critical care units where the provision for tea and coffee making and microwaves were available.
- The NICU had a family interview room that was used as necessary to speak to parents in confidence including when the need arose to break bad news.
- We examined the GOSH Operational Plan Document for 2014-16 which showed that the demand and capacity analysis of NICU was adequate for future projected admissions over a three year period. NICU was able to deal with capacity issues in the region.
- We noted that GOSH and NICU work in partnership with University College London (UCL) and this partnership has created the UK's only academic biomedical research centre specializing in paediatrics. The mission of the UCL Institute of Child Health is to improve the health and well-being of children, and the adults they will become, through world-class research, education and

public engagement. We ascertained from the GOSH operational plan for 2014-16 that the plan was developed through wide consultation with local and national stakeholders to ensure that GOSH has a responsive, relevant and robust approach to development which is consistent with its vision for specialist children's health care

- Where people's needs were not being met, this was identified and used to inform how services are planned and developed. This has been achieved through a range of public liaison events such as the listening event conducted in 2012 where staff met with family service users and conducted group consultations.
- Similarly NHS England, through the patient experience network, commissioned a report entitled Improving Patient Experience for Children and Young People, which investigated how neonates and their families/carers could have a positive experience of care.
- The NICU facilities were purpose built and designed and are appropriate for the services that are planned and delivered.
- Babies that required home ventilation care and long term ventilation weaning were managed on Miffy Transitional Care Unit. This unit is specifically designed to support babies who require long term respiratory support and care. They are supported by a dedicated cardio-respiratory group of physiotherapists. All parents were given a ward based competency book to complete to help them develop the skills they need prior to discharge home.

### Meeting people's individual needs.

- Staff we interviewed were fully aware of the on-going care needs of babies with complex needs and mindful of an individual child's long term care.
- Staff were able to access interpreters either in person or via telephone for families who did not speak English.
- For those parents of babies who had died on the NICU there was a bereavement room with sleeping facilities and a cold cot to allow these parents to spend time with their deceased child.
- We noted that play materials were available for visiting siblings and saw them being used; the NICU had access to a play therapist as required.
- The NICU had parent waiting areas and accommodation for the families of babies in a building a short walk from the hospital.



# Neonatal services

- Translation services were available so that parents for whom English was not their first language were able to communicate with the staff.
- As all admissions to NICU were emergency admissions parents were provided with a snack pack and personal hygiene pack, including fresh water, toothpaste, shampoo and conditioner by the CATS team.
- To support breast feeding mothers and to ensure they had access to food, all received a daily food voucher to use in the hospital restaurant.
- Mothers who were resident with their baby in NICU received their post-natal care from the community midwives at University College London Hospital (UCLH) and a post-natal clinic was held three days each week at GOSH.
- Breast pumps were available on NICU and parents were able to take them to the parents' hospital accommodation.
- During our visits to NICU we examined a variety of bespoke information/advice leaflets and posters around the unit. e.g. hand washing and the Information For Families leaflet (also available on line)
- Bliss (Baby Life Support Systems) is a UK charity which works to provide the best possible care and support for all premature and sick babies and their families. During our inspection of NICU we noted that Bliss literature was available throughout the unit for parents including what they could expect and how they could be involved in their baby's care.
- We inspected the information for parents on pain management complied by the pain control service in collaboration with the Child and Family Information Group which was updated in June 2014.
- There were facilities for mothers who were expressing their milk, these were in individual rooms and the breast milk pumps were noted to be fit for purpose and in line with national guidance. Mothers staying in the parent's accommodation were given breast pumps in their room to avoid the need of the mother having to return to the NICU to express her milk.
- We noted the visitor toilet facilities were inadequate in number.
- There was a visitor's waiting area providing families and relatives with an area to take a break away from the incubator.

- There was an identified parent's room on NICU which was used for medical and nursing staff when wishing to speak to parents especially when they needed to break bad news.

## Access and flow

- The bed management policy provided guidance of how patients would be prioritised in times of extreme pressure. This stated that those patients ready for transfer from the NICU to ward areas would be given priority. The bed management team were responsible for monitoring bed capacity, which was discussed at the daily operational bed meeting at 09.30am, Monday – Friday.
- The Intensive Care Outreach Network (ICON) and Clinical Site Practitioners (CSP) are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours a day, seven days per week. They facilitated the readmission of patients to NICU as required.
- Babies transferred out of NICU to the wards and HDU areas were monitored by the CSP team and the ICON team for 48 hours post transfer to ensure any deterioration was identified in a timely manner.
- The bed occupancy for critical care as a whole was reported to be 86.5% each month between August 2013 and November 2014. This was higher than the England average over the same period of 79.6%.
- The 2014-2015 GOSH quality report demonstrated that six simultaneous work streams were initiated by a dedicated team with the overall aim of reducing the number of NICU bed hours lost to avoidable delays or cancellations, by 31st December 2014.
- All admissions to NICU both internal and external, were discussed with the consultant in charge and the referring doctor to ensure the NICU was the most appropriate place for the child to be cared for.

## Learning from complaints and concerns

- A parent representative was invited to the monthly critical care division meetings to promote transparency and to ascertain family satisfaction with service delivery in NICU and the other units.
- The PALs service managed complaints such as parent accommodation and resolved these.
- The complaint's team co-ordinate the response to any complaint with the input from NICU.

# Neonatal services

- Although there were very few complaints about NICU the staff we spoke with confirmed that lessons from complaints were cascaded and discussed at NICU meetings.
- Although complaints were few in number some parents had complained about the food service and in response the catering department had reduced the amount of processed food and had increased the number of healthy options available to parents. Freshly made halal meals were available at each mealtime in the Lagoon restaurant and kosher meals were also available on request.
- We saw examples of how the service had learned from complaints. For example after many complaints by parents about smoking within the covered walkway entrance to the hospital a sensitive smoke alarm using voice technology was installed.

## Are neonatal services well-led?

Good



The NICU unit had an open, caring and supportive approach. Professional and team relationships among the staff were good. There were some concerns among the nursing staff generally within the wider critical care unit that the aspirations of the Trust were primarily medically led and failed to adequately reflect the contribution of nursing. However nursing staff felt supported by the senior nursing team and able to raise concerns. There was good support for the new chief executive and his vision for the future of the trust.

Many of the staff and parents we spoke with were fully aware of the Trust corporate plans and aspirations for the service.

### Vision and strategy for this service

- There was a vision and strategy for the service in the form of an annual divisional plan that documented the objectives of the service; progress against these objectives was reported via the performance review framework.
- Consultants we spoke with stated that the new CEO had a clear vision for the future direction of the trust.

- The trust's mission and core values were displayed on a variety of posters throughout the NICU. The core values were also displayed on all screen savers on the NICU computers.
- Staff we spoke with on NICU all supported the philosophical mission statement of the trust, i.e. "the child first and always".
- We were informed by many of the nurses we spoke with that the trust vision of becoming the world's premier children's hospital, was failing to reflect the contribution of nursing in this vision.
- The staff we spoke to in NICU were aware of the service priorities for the unit and these had been discussed in NICU meetings.
- The new chief executive has shared the corporate vision, values and strategy for the development of the trust through open staff meetings within the large open area of the trust (The Lagoon) and nurses we spoke with in NICU had attended these open meetings
- All the staff we spoke to in NICU appeared to know and understand the vision and values of the trust.
- Staff we spoke to including housekeepers were aware of the trust strategy and their role in bringing it to fruition.

### Governance, risk management and quality management

- The critical care division including NICU had a documented governance structure that identified the reporting arrangements for individual groups and meetings.
- The critical care manager told us that monthly risk meetings took place in NICU. The minutes of these meetings that we examined demonstrated that they were attended by all grades of staff and the topics discussed included a review of learning from adverse incidents.
- The risk register for NICU that we inspected included risks such as medication administration errors with identified actions to be taken to mitigate these risks. The date the risk was identified, entered on the register and reviewed was recorded. Some risks had been on the risk register for over three years. Some of these risks were stated to be accepted risks but others such as clinical results not being annotated on the electronic flow sheet had been on for over three years but not resolved.

# Neonatal services

- The critical care services risk reports dated April 2015 and April 2014 were presented at the risk action group and cascaded to all NICU and other critical care staff.
- The monthly critical care board meetings were attended by the senior managers of the NICU and a range of discussion topics presented including issues of quality and safety. The minutes for the September 2014 meeting submitted prior to our inspection showed that actions to address issues raised were identified and assigned to individuals to respond to. However, the minutes were brief and did not demonstrate progress on previous action and therefore it was not possible to assess the effectiveness of this group in completing actions.
- Clinical governance meetings were held and incidents and risks were identified and discussed. We examined the board minutes of the 25th March 2015, which provided an update from the Clinical Governance Committee in January 2015. This discussed the successful implementation of the GOSH plan to increase Intensive Care Unit provision.
- The Staff we spoke with on NICU knew how to escalate risks onto the risk register when an incident had been reported.
- The various grades of medical, nursing, allied health professionals and ancillary staff we spoke with were clear about their roles and they told us that they fully understood what they were accountable for in health care delivery.
- We were informed by the senior nurses and consultants we interviewed within NICU that there was a systematic programme of clinical and internal audit, which was used to monitor quality and to implement systems to identify where action could be taken. For example within NICU a new guideline had been developed by the neonatologist for the identification of acute abdomen in high dependency care neonates.

## Leadership of service

- There was identified nursing leadership at unit level with senior nursing staff being visible and approachable, supporting staff, ensuring training was completed, and addressing any issues in a timely manner.
- Staff we spoke to in NICU recognised that the chief executive was new in post but were familiar and supportive of his emerging strategy.
- There was a lead designated Clinical Director for the critical care division.

- The senior nurses and sisters we spoke to confirmed that there was a supernumerary clinical coordinator (sister/ charge nurse bands 6/7) on duty 24/7 within the domains of the critical care unit. We noted this after attending an early morning handover on NICU.

## Culture within the service

- The NICU had an open, caring and supportive approach. Care was delivered as team effort and there was effective team working.
- The staff we spoke with were positive about the quality and care that they gave to babies and were all highly supportive of the trust's mission statement
- We observed that staff in NICU worked well together and showed respect for each other.
- The nurses we spoke with told us that they felt very well supported with one NICU nurse stating 'since starting at the trust all my stress levels have reduced in comparison to my previous job' others told us break times were protected and they received regular breaks.
- We were informed that there were effective relationships between junior nursing and medical staff across the three units of the critical care service.
- There was a tangible culture centred on the needs and experience of families who use services centred around the trust mission statement.
- We noted a strong team approach to care delivery on NICU with a strong emphasis on promoting the safety and wellbeing of staff.

## Public and staff engagement







- Staff we spoke with had attended the chief executive's open forum meetings, at which the future vision and strategy for the hospital was shared.
- Staff reported that email was used as the main form of communication with briefings and newsletters sent via this medium.
- Parent engagement was promoted at the weekly unit meetings with family representation being sought for the larger full monthly critical care division meetings.
- The staff we spoke with considered that they were actively engaged in the planning and delivery of services and in shaping the culture of the trust.
- The public engagement strategy adopted by the trust was an effective method of soliciting public opinion.

## Innovation, improvement and sustainability.

# Neonatal services

- The nurses and doctors and allied health professionals we spoke were highly motivated and focused on continually improving the quality of care. We noted during our attendance at handovers that there were up to date evidence based care journals available for staff to read.
- The GOSH newsletters we examined (e.g. April 2015) showed how information about the care of children with learning disabilities for example was used to proactively improve care.

# Transitional services

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

## Information about the service

In healthcare, Transition Services are involved in planning, preparing and moving young people from children's healthcare to adult healthcare. Around a quarter of the trust's inpatients and around a third of its outpatients were aged 11 and above and required transition planning to adult services. These included children treated at the Great Ormond Street site and at satellite services at 67 different locations.

There were ten specialities which had established transition arrangements in place. Within these specialities transition services had been developed independently and links with other hospitals able to provide on-going care had been forged. We were aware that other specialities had a form of transition arrangements in place however these were not being audited under the current CQUIN.

During our inspections we visited eight inpatient areas and clinics within the outpatient area. We spoke with twelve young people, nine parents and 36 staff. We observed care and treatment and reviewed seventeen pathways of clinical care looking at transition procedures for young people moving into adult services. Before the inspection, we viewed performance information from, and about, the hospital.

## Summary of findings

Young people were being treated with dignity, respect and compassion. Clinical teams supporting care were committed to supporting young people requiring transition services. We found examples of excellent care pathways for young people with specific long-term health needs transitioning to adult services.

We saw evidence of trust wide "Transition to Adult Health Services Integrated Care Pathway" (ICP) audit and re-audit of "transition arrangements for young people". An initial audit in 2012 had shown 0% compliance with transition documentation and planning. This was found to be because transition plans had previously been held locally with no centrally held record. Improving transition to adult services had been identified as a GOSH Commissioning for Quality and Innovation (CQUIN) target for 2013-2014. The ten speciality services where transition had been established were audited. The latest figures show a significant improvement has been made from 34% compliance in 2013-14 to 64% compliance in 2014-2015. The trust were planning to extend the CQUIN and audit a further five clinical specialities in 2015-16.

However, we found that there was no overall responsibility or leadership for transition services in the trust at board level.

# Transitional services

## Are transitional services safe?

Good



We rated transition services good for safety.

The Trust had an overarching Integrated Care Pathway (ICP) in place for the transition of young people to adult services. Most specialities had devised appropriate integrated care pathways using national guidelines and NHS England to ensure young people transferred safely to adult services.

### Incidents

- There had been no never events recorded for transition within GOSH.
- Staff were aware of how to report incidents via Datix (the trusts electronic incident reporting system). Staff told us that they always received feedback within two to three weeks or sooner if the incident was serious.
- There was clear evidence of learning from incidents. Staff shortage was the most frequently recorded incident. Short staffing often occurred due to staff leaving due to their own family commitments. The trust had responded to this frequent recording and had offered flexi-part time shift patterns to help retain staff. A nurse we spoke to told us it has made a great deal of difference to them and personally and had led to safer staffing levels on their ward.

### Cleanliness, infection control and hygiene

- All wards and clinical areas we looked at were visibly clean and well maintained.
- There had been no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) and 15 cases of clostridium difficile (C-Diff) from January 2014 to January 2015.
- There were hand gels inside and outside of ward areas and in reception and we saw staff using them appropriately.

### Environment and equipment

- Most wards where transition patients were located were bright and airy with good use of age appropriate art work which made the environment look inviting for young people.

- One member of staff told us that the Miffy Transitional Care Unit was "not fit for purpose" but that they were making the best of it. A senior staff member told us that they had made complaints regarding the cramped environment on their other ward (Badger) which resulted in a move to another ward on a higher floor.
- There were plenty of age appropriate toys from puzzles to computer games. Some wards had "sensory rooms" with a variety of lights and related equipment.
- Some ward areas had teenage rooms where teenagers could go and relax away from the noise of the wards.
- The equipment on the wards was well maintained. We saw evidence of regular safety checks being performed at ward level and annual Portable Appliance tests (PAT) performed by the estates department.

### Medicines

- As part of transition pathways, for example on the cardiac ward, we were told young people and their family members were being taught how to administer their own medications. They were tested on their knowledge and technique before being discharged from hospital. This was done in line with the trusts "medicines administration policy". One 15 year old we spoke to who was about to leave the hospital told us, all the names of his medications, when to take them and what they were for. He said "I really love being treated like an adult; I have a problem with my body not my brain".
- The electronic prescribing system included the means to record administration of medicines by parents.
- We saw evidence of appropriate prescribing, signing, safe storage and documentation around medications being administered.
- However nursing staff told us they found the electronic prescribing system could be difficult to navigate.

### Records

- Transition records were variable throughout the trust. We saw that most young people over the age of 11 on other wards such as Koala, Rainforest and Kingfisher, did not have transition care pathways. All wards had access to the trust wide transition care pathway however the majority of other wards were choosing not to use it. Staff stated the trusts transition care pathway



# Transitional services

was too large, time consuming to complete and too generic. However in the speciality areas such as cardiology, transplant and cystic fibrosis wards all young people were on a transition pathway.

## Safeguarding

- Staff told us they were knew how to report safeguarding concerns to the safeguarding team. However we were not given any specific incidents where they had done so.

## Mandatory training

- Transition training was given to all new staff on induction. However some staff who had been employed by the trust for a long time told us they had never had any specific training in this area. Doctors received transition training as part of their Continuing Medical Education (CME) programme. The trust had no named person to deliver transition training, However the Adolescent Clinical Nurse Specialist (CNS) had assumed responsibility for this role.

## Nursing staffing

- Staff reported that staffing levels were low and that band 7 posts in some areas had been either frozen or cut. The “Safer staffing report” of February 2015 showed staff vacancies existed across the trust, However there had been no unsafe shifts reported on the wards.
- All the staff we observed were confident and competent in the roles and care they were providing.
- A Clinical nurse specialist (CNS) who was running a transition care pathway told us “I am a one person service, I cannot see everyone I would like to once they have left GOSH”.
- Parents praised the nursing staff but said they were “run off their feet”.

## Medical staffing

- Doctors treating transition patients were attached to their own speciality and department.
- We saw no evidence of locum doctors being used.

## Are transitional services effective?

Good



We rated effectiveness of transition services at the trust as good.

We saw evidence of trust wide “Transition to Adult Health Services Integrated Care Pathway” (ICP) audit and re-audit of “transition arrangements for young people”. An initial audit in 2012 had shown low compliance with transition documentation and planning. Prior to 2013/14 it was difficult to assess compliance with Department of Health transition recommendations due to transition plans being held locally and not centrally in the trust. Improving transition to adult services had been identified as a GOSH Commissioning for Quality and Innovation (CQUIN) target for 2013-2014. As a result the latest audit figures show a significant improvement has been made from 34% compliance in 2013-14 to 64% compliance in 2014-2015. The trust were planning to extend the CQUIN and audit a further five clinical specialities in 2015-16.

There were some very positive examples of effective pathways and robust transition arrangements that were securing positive outcomes for young people. A transition care pathway devised by the Cardiology CNS has been adopted for use in other London hospitals. However transition services were not always a positive experience for all the young people we spoke to. For example, two young people we spoke to were still awaiting appointments with their adult services up to two years after leaving GOSH. It was not clear if this was the fault of GOSH or the ongoing hospitals. Staff told us that other young people receiving dialysis for renal dysfunction often had rushed transitions due to the availability and urgency of accepting an adult space.

## Evidence-based care and treatment

- Young people were treated according to national guidance, included those from the National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics and Child Health. Policies and procedures were based on current national guidelines.

# Transitional services

- Transition services for cardiology and cystic fibrosis were highlighted as examples of excellence. Trust-led research for evaluating a baseline for all transition pathways was being led by the research department to identify excellent practice.
- Research by a junior doctor on the transition from paediatric to adult services for young people with Sturge-Weber Syndrome (SWS) a rare disorder with complex associations had been completed. The results highlighted that the needs of young people with SWS were not being adequately met by the transition to adult services. Recommendations for future improvements were transition care pathways to be adapted to suit young people with disabilities, to identify adult services with SWS and to set up a joint transition clinic.
- The cardiology CNS had produced a set of book's "Fight for every Heartbeat" a series of three booklets based on research with the British Heart Foundation. The books cover the practicalities of becoming a young adult with a heart condition. The books are being used nationally.

## Multidisciplinary working and joint clinics with adult services

- Within the speciality transition teams there was positive evidence of multi-disciplinary working within the trust, for example "Rhythmic Beats" which is described as a one day boot camp on transition. This includes issues young people may face on drugs, alcohol and smoking with outside speakers coming into GOSH to speak on these topics.
- There was evidence of positive multi-disciplinary working between the trust and Adult services. Ten specialities had forged links with other hospitals to provide on-going adult care.

## Are transitional services caring?

Outstanding



We rated transition services overall Outstanding for caring.

Specialist teams provided compassionate care with good emotional support through transition. Parents and young people felt that members of staff truly valued them as individuals, staff spoke to them at an appropriate level of

understanding and explained things clearly. People's emotional and social needs were highly valued by staff and were embedded in their care and treatment. Young people felt consulted and included in their care and treatment. Young people and those close to them were treated with dignity, compassion and respect. Young people were being respected and valued as individuals and were empowered as partners in their care.

## Compassionate care

- We observed all staff provided compassionate and sensitive care which met the needs of the young person and their parents.
- We observed members of staff who had a positive and friendly approach towards the young person and parent. We saw staff explaining what they were doing and if requested by the young person would accompany them to their next stage appointment.
- The parent of one young person explained how she observed a child who was nil by mouth getting upset when she saw others eating. A nurse pulled the curtain round the bed and gave her a selection of games to play which calmed her.
- People we spoke with thought that staff go the extra mile and the care they receive exceeds their expectations. For example a consultant had applied for funding from drug companies, to enable young people to attend camps and take part in the European transplant games, as this would not be typically part of trust baseline funding.

## Patient/ families understanding and involvement

- We observed members of staff and doctors who talked with adolescents at an appropriate level of understanding. For example we saw a doctor having a joke with a young person regarding an internet game. A relative told us "That's the first time he has smiled in weeks".
- Young people on the wards we talked with told us they felt fully involved in the planning of their care and treatment. One young person told us "The Doctors and nurses treat me like an adult. My doctor told me about the medications that were available to treat me and I decided after doing my own research on the internet which ones I would prefer to take".

# Transitional services

- Most young people told us they had found the prospect of moving to a different hospital daunting however they had been fully involved in their transition process and one had been able to choose their on-going hospital.
- Most young adults felt the transition process used had fully involved them in decisions about transition between the two services and was tailored to meet their own needs.
- We observed during the inspection that relationships between people who use the service, those close to them and staff were strong, caring and supportive. For example staff invited young people and their families to be involved with the transition information days and events such as “Rhythmic beats”.
- We spoke with two young adults and one of their parents on the telephone after they had left GOSH and gone through the transition process. Both young people sat on the Young Peoples Forum (YPF) and one on the Foundation Trust board of governors. One young person described their transition as described their transition as “It could have been better” and one described the process as “Shambolic”. Both were still waiting forwarding appointments, one two years after leaving GOSH.

## Emotional Support

- We observed during the inspection that relationships between people who use the service, those close to them and staff were strong, caring and supportive. For example staff invited young people and their families to be involved with the transition information days and events such as “Rhythmic beats”.

## Are transitional services responsive?

Good



We rated the responsiveness of the transition service as good.

We found excellent examples of the trust and staff being responsive to young people's needs. We saw many examples of outstanding practice throughout the hospital. Consultants and clinical nurse specialists had forged relationships with hospitals and services providing adult care. They organised clinics and events so young people

could meet their on-going care team before leaving GOSH to help ease the path of transition. We were not assured of the coordination of transition arrangements to support young people with long-term complex health needs through transition to adult services.

## Service planning and delivery to meet the needs of local people

- Specialist nurse-led clinics focused on providing young people with support relating to health and emotional needs. For example the “Rhythmic beats” clinic that covers topics such as alcohol, drugs, sex, relationships and feelings.
- Transition pathways were driven by the young person's primary health need and we found areas of excellent practice when reviewing transition planning for specific medical health needs. From speaking to young people, families and staff and reviewing care pathways, it was clear that strong relationships with other adult providers was key to the success of transition into adult services.
- Young people, in some instances, were supported after the age of 18, with decision making based on best interests, within clinical pathways and patient choice – for example, in Sturge-Weber syndrome a congenital neurovascular disorder where young people have multiple complex needs. However, we were concerned that some young people were still supported by the trust after the age of 18. Doctors and nurses told us that they were concerned about the availability of services elsewhere for young people with complex needs when they reached adulthood.
- The process and responsibilities of coordination of services for young people with complex needs, and how they were identified as requiring transition planning to adult services in the future, was unclear. We did not find an evidence to support a transition structure was yet in place to cover all young people with complex needs.
- Young people with learning disabilities were supported either as part of pathways or through clinical and health play therapy teams.
- We saw evidence of consultants who were going the extra mile to undertake research, forge relationships with other hospitals and raise awareness of the need within the trust of the benefits of getting transition serviced right.

# Transitional services

- Transition pathways were driven by the young person's primary health need and we found areas of excellent practice when reviewing transition planning for specific medical health needs. From speaking to young people, families and staff and reviewing care pathways, it was clear that strong relationships with other adult providers was key to the success of transition into adult services.
- A young people's forum had been set up which involved a surgery theatre sister engaging with young people to look at what improvements theatres could make to enhance their experience.
- There were comprehensive information leaflets in relation to transition care. For example, information leaflets regarding "Transition to adult services for children with learning disability. Some of these had been in pictorial format called "A picture tells a thousand words" for ease of understanding.

## Meeting people's individual needs

- There were comprehensive information leaflets in relation to transition care. For example, information leaflets regarding "Transition to adult services for children with learning disability. Some of these had been in pictorial format called "A picture tells a thousand words" for ease of understanding.
- From our conversations with transition patients and their carers and parents we noted that there was often a problem obtaining suitable on-going services once the patient had left the direct care of GOSH.

## Are transitional services well-led?

Requires improvement



We found that leadership in transition services required improvement. There were some excellent examples of good practice identified across pathways of care. However reporting arrangements to the board were unclear for these services. There was a Young People's Forum and a Nurse Consultant and adolescent CNS who were informally nominated as the Trust's lead for transition care. However, the group did not have the authority, time or resources to develop and promote a coordinated approach to transition care across the trust. Therefore, reporting arrangements to the board were unclear for these services. There was an

overarching strategy and vision relating to transition services within the trust but no named people or resources to administer it. There was no one with responsibility for transition at board level.

## Vision and strategy for this service

- We were not able to see detailed plans outlining a standardised framework and care planning approach for transition care, both locally or nationally. We found some national guidelines for example "Adolescent Transitional Care" nurse guidelines from Royal College of Nursing (RCN) but no standardized framework.
- Vision and strategy related to adolescent care and transition services had been driven effectively by clinicians within ten named clinical areas identified by the 2013-14 Commissioning for Quality and Innovation (CQUIN). This was extended to include five other specialities in 2014-15.
- Staff were not clear who was the trust lead or who had overall responsibility for transition services. A senior clinical nurse specialist and a nurse consultant had assumed the role but we saw no leadership for the service at trust board level.

## Governance, risk management and quality measurement

- Future commissioning arrangements include Commissioning for Quality and Innovation (CQUIN) were unclear. There was a wish at ground level to include a further five clinical areas if the CQUIN were to extend to 2015-16.
- The Trust had facilitated a Young Person's Working Forum (YPF) over a number of years. This group had previously met six times per year and attendance has included members of staff who have a specific interest in adolescent and transition care. Some recent meeting minutes we reviewed noted that the group had previously contributed to various events such as "Rhythmic beats". The YPF members were also contactable for advice through the YPF Facebook and twitter pages.
- We were informed by the CNS who had assumed responsibility for transition care services that although

# Transitional services

the YPF group did not carry any authority to drive through change they were driving and starting to influence policy. The chair person and four other YPF members had been elected into the members council.

- There is no committee who oversees transition within the trust and no joined-up systems in place. Individual services have developed their own transition vision and care pathways individually. However there was no overall trust co-ordination of these to ensure best practice was shared and consistency being achieved.

## Leadership of service

- There was limited evidence which demonstrated Trust wide coordination of young peoples transition services. This meant transition services had an inconsistent approach across the hospital.
- The development and responsibility for transition services lay with the individual speciality team and we saw limited evidence that demonstrated this was monitored at trust level.

## Culture within the service

- Within the speciality teams who provided transition services we found they had members of staff who demonstrated a passion for the robust and successful transition of their adolescent to adult services. For example the cardiology, oncology, renal transplantation teams based at GOSH demonstrated a real commitment and passion to their service for adolescents and their transition to adult services.

- Outside of these services we could not establish how the trust and staff culture felt regarding the care of adolescents and their transition to adult services. Some staff we spoke with showed limited awareness of how adolescents transitioned to adult services.
- One CNS told us “We have been trying to raise the profile of transition across the trust over the last two years. We feel we will get there one day”.
- However a consultant told us when speaking about clinical specialities “the trust is full of ivory towers, with all of us doing different things. Therefore there is little cohesive working or sharing of good practice”.







## Public and staff engagement

- The Trust provided examples of how it had utilised social media sites to engage with adolescents. These included “Being a teenager at GOSH” and “Transition to adult services” web-page, Facebook and Twitter where young adults can contact others going through transition for help and advice.
- There was a range of opportunities for young people to feedback their experiences, through Facebook and Twitter.

## Innovation, improvement and sustainability

- There was evidence which showed the cardiology CNS had been involved in sharing transition work developed in GOSH within London and nationally. The work completed, included a transition to adult services care pathway, “Fight For Every Heartbeat” booklets and “Rhythmic Beats” which was an adolescent boot-camp to prepare young people for transition.

# End of life care

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

## Information about the service

The palliative care and end of life service at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is a multidisciplinary service provided by medical and nurseconsultants. They provide tertiary specialist paediatric palliative care across the paediatric spectrum from the antenatal period, through infancy and childhood and also for young people up until their 19th birthday.

Palliative care is the active, total care of patients at a time when their disease is no longer responsive to curative treatment. The palliative care team (PCT) supported children and young people (C&YP) with conditions that may be cured, but where treatment may not be successful and a child could die (life-threatening conditions) or for those that cannot be cured and where death in childhood is likely (life-limiting conditions). There are four categories of life-threatening/life limiting illness.

**Category one:** Life-threatening conditions for which curative treatment may be feasible but can fail. Where access to palliative care services may be necessary when treatment fails or during an acute crisis, irrespective of the duration of that threat to life. On reaching long-term remission or following successful curative treatment there is no longer a need for palliative care services. For example: cancer, irreversible organ failures of heart, liver and/or kidney.

**Category two:** Conditions where premature death is inevitable, where there may be long periods of intensive treatment aimed at prolonging life and allowing participation in normal activities. For example: cystic fibrosis and Duchenne muscular dystrophy.

**Category three:** Progressive conditions without curative treatment options, where treatment is exclusively palliative and may commonly extend over many years. For example: Batten disease and mucopolysaccharidoses.

**Category four:** Irreversible but non-progressive conditions causing severe disability leading to susceptibility to health complications and likelihood of premature death. For example: severe cerebral palsy, multiple disabilities such as following brain or spinal cord injury, complex health care needs and a high risk of an unpredictable life-threatening event or episode.

The PCT work within the hospital and provided community outreach to support children and their families, clinical teams and day care teams by offering emotional and practical support, giving advice on symptom management and practical issues during the child's treatment and if they were to relapse. The support offered by the team varies according to the needs of each child and family and the nature of the child's illness from diagnosis till death and beyond.

GOSH offered bereavement support for those families whose care they were involved with before the child died. They arrange local support and specialist help if it's required. This is in conjunction with the work done by the bereavement services based at GOSH.



# End of life care

The Louis Dundas Centre at Great Ormond Street Hospital is a centre of research, teaching and practice in palliative care for children and young people. The centre aims to deliver the highest standards of palliative care and model best practices. It also plays a role in the development of an evidence base for paediatric palliative care and in the dissemination of the results of research through publication, education and training. Working alongside the centre's PCT are dedicated researchers who collate information from patients and their families, and undertake a research programme that seeks to improve and advance clinical practice and policy.

We spoke with a full range of staff that included: seven consultants, three junior medics, seven specialist nurses, 16 nursing staff of different grades and included the senior nurse leads, two allied health professionals which included psychotherapy and pharmacy, five members of the chaplaincy team, one member of bereavement services and two members of the mortuary team. We also heard the views of staff attending focus groups.

We spoke with four parents. We observed care and the environment. We looked at ten sets of medical records and hospital data such as audits and policies and procedures.

## Summary of findings

Parents we spoke with could not praise the quality of the care and support given by GOSH any higher. One parent wrote in an email, "GOSH and the healthcare professionals involved in our child's care are leading the world in paediatric care." All staff across the hospital were found to be compassionate, caring and considerate and wanted to do the best they could for children and their families.

The vision of the service was for children and young people (C&YP) to live well and maintain their quality of life for as long as possible. We found that care and treatment was safe, evidenced based and followed accepted standards and professional guidance. There were clear care pathways for children being cared for in the hospital and community and all parties involved in the child's care were included in these plans.

There was excellent multidisciplinary team working in palliative and end of life care services which included chaplaincy and dedicated psychological and social support teams. They liaised with and advised community nursing teams, GPs, schools, pharmacists and the London Ambulance Service in how to support a child or young person with life limiting or life threatening condition when living at home or in a hospice. We found that medical records were completed appropriately and the views of the child and their family were fully taken into account. An ethics committee safeguarded C&YP interests in the event of a conflict in care and treatment.

Children and their families were given the choice as to whether they wished to receive end of life care at the hospital, at home or in a hospice. The service took into account individual circumstances and needs and supported them in their decisions without judgement.

End of life and palliative care was well-led. The team were thought of highly by colleagues within the hospital and by other professionals from around the world. The PCT told us they were visited by many other organisations to learn from them. They took the views of children, families and staff into consideration and

# End of life care

shared learning. The team were passionate about continually improving the service, which included training programmes for nurses and GPs from hospitals and surgeries around London.

## Are end of life care services safe?

Good



We rated safety in end of life services good.

People were protected from avoidable abuse and harm through a comprehensive safety system, and focus on openness, transparency and learning when things go wrong. Although there had been no recent incidents staff were aware of the system for reporting them. The team held regular meetings and any points of concern were discussed.

We found that medical records were completed appropriately and the views of children and their family were fully taken into account. There were effective systems in place for prescribing and administering medicines to patients receiving end of life care within the hospital and the community.

We found there were systems in place to manage a baby, child or young person's deteriorating medical conditions. There were symptom management and emergency treatment plans which took into account their individual prognosis and systems for reacting to critical clinical events. All these procedures were proactive while allowing staff to react quickly in emergency situations.

With regard to safeguarding procedures we found that the majority of staff had been trained in safeguarding children and adults and those we spoke with were able to fully explain their role. All staff were required to complete mandatory training. However trust data showed that the teams involved in end of life and palliative care had not completed all their mandatory training modules to the trust's required standard of compliance.

### Incidents

- Serious incidents known as 'Never Events' are largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented. End of life care (EoLC) services had not reported any never events or serious incidents (SIs) during 2014.
- The Learning, implementation and monitoring board (LIMB) met on a monthly basis to consider learning identified from a variety of sources including serious

# End of life care

incident (SI) investigations, complaint investigations, PALS data, safeguarding investigations and clinical audit. Staff received the LIMB newsletter highlighting the key messages identified each month. Staff told us LIMB was discussed at the PCT's business meetings. They spoke positively about the LIMB newsletter and opportunity to discuss the outcome of investigations across the trust.

- Incidents relating to EOLC and palliative care were discussed during the end of life group meetings. The mortality review group reviewed every child death under the 'child death review process'.
- Trust records showed there had been no reported medication incidents relating to palliative care admissions to the hospital. There was one medication error incident within the community which was addressed with the local GP.

## Medicines

- The service leads told us the multidisciplinary team meetings relating to medication meant there was room for challenge when discussing C&YP medication regimes. They described safe practices such as starting with small doses of medication with slow increases if there was a favourable result.
- The PCT discussed C&YP needs with community pharmacists and supported parents in correct administration to ensure they were being supported safely and appropriately when living in the community.
- The PCT nurse consultant and one of the clinical nurse specialists (CNS) were independent non-medical prescribers. This meant they could prescribe medication to patients without medical involvement.
- We saw innovative practice in finding palatable ways of administering medication to children such as through Lactulose lollies.

## Records

- We found medical records contained appropriate information regarding clinical care and treatment. These included a symptom management plan (SMP), emergency care plan (ECP) which indicated the level of care agreed, contemporaneous records of interventions, advice from the PCT, and contact details of others involved in the child's care. Ward staff spoke positively of the SMP as they experienced few deaths they said it was a useful tool to follow.

- Notes were laid out well and information was concise, clear and legible. Difficult conversations were well documented and the discussions noted were clear to understand.
- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the folders for easy access.
- Symptom management plans were easily accessible at the front of the notes. These were updated on a regular basis, taking into account any changes in the child's condition. We noted in one set of records there was a plan for February and March 2015. The incorrect plan could easily have been used without prior checking as the old plan had not been scored through or removed to another part of the folder. We raised it with the consultant in paediatrician palliative medicine and it was dealt with appropriately and immediately.
- The PCT's database contained all details for children under their care. This information included contact details, their emergency care plan, medical records pulled from the hospital electronic recording system, the contact details for everyone involved in the child's care (including schools) and activity such as visits, phone calls and outpatient appointments.
- The PCT told us the database was invaluable for tracking the children under their care as the system ensured that a child was not lost within the organisation and was not discharged from their care until appropriate care was sought or the child no longer required their support.
- The database had also improved consistency and the quality of notes and letters as well as speed up administrative tasks such as changes in contact details. Any outstanding work was flagged for follow up.

## Safeguarding

- All staff were trained in safeguarding children and adults as part of their mandatory training. They could access the trust policy and procedure through the internal intranet system.

## Mandatory training

- The trust deemed a score of 95% and above as an acceptable standard of compliance for mandatory training.
- Trust records showed the palliative care (symptom care) team were 100% compliant in 11 out of 23 mandatory training modules expected to be completed. Modules

# End of life care

where they achieve 100% compliance included safeguarding children level 1 and 3 and safeguarding adults' level 1, infection prevention and control level 1 and information governance. Modules where they had not achieved the required standard included safeguarding children level 2 (77%), consent and parent responsibility (PR) (69%), medicine management (69%), infection prevention and control level 2 (62%), pain pumps management practical PCA NCA epidural (38%), resuscitation level 3 (46%). Blood transfusion paediatric level 1 and 2 (50% and 0%), and parental responsibility for non-clinical staff (67%).

- The chaplaincy had achieved 100% compliance in eight out of 14 mandatory modules, which included safeguarding level 1, infection prevention and control level 1 and information governance. The modules they had not achieved the required 95% included safeguarding adults level 1 (85%), infection prevention and control level 2 (0%) and consent and PR (29%).
- Bereavement services had achieved 100% in 11 out of 14 modules. These included safeguarding children and adults' level 1 and infection preventions and control level 1 and 2. They were not compliant in moving and handling clinical patient handlers (50%), fire safety (face to face training) (67%) and consent and PR (0%).
- The mortuary staff came under the histopathology staff, we were unable to ascertain from the information given by the trust as to whether the two staff members had completed all the required mandatory training modules as they were counted within the total numbers for this division.

## Assessing and responding to patient risk

- Hospital staff had access to a guide for EOLC. The handbook was aimed at staff who had limited experience of looking after those approaching the end of their life. Its purpose was to help staff support C&YP and their families and utilise resources that were available within GOSH and externally. It provided staff with clear six steps guidance from discussions as the end of life approached to care after death and included a paediatric palliative screen scale to help them consider whether a child would benefit from the introduction of discussions around palliative care. Early introduction to palliative care allowed the family time to plan how and where they would like to spend their time if death became a likely outcome.

- All C&YP referred to the PCT were triaged by the nurse as urgent or routine at first referral within 24 hours of admission to the PCT. All new referrals remained on the palliative care database until they had been reviewed at the referral panel meeting which took place at the weekly multidisciplinary (MDT) meeting. Referrals which did not meet the PCT's required criteria remained on the system until appropriate support had been arranged through alternative sources.
- The Children's Early Warning Score (CEWS) was used to assess a child's level of critical illness and deterioration over time. Matching scores to a set algorithms (zero to two, three to four and five plus) acts as another means to clinical decision making. The hospital provided nursing staff with a CEWS reference card. This was the size of a credit card and easy to carry with their NHS ID card. On the reverse of the card staff were prompted what information the nurse-in-charge, registrar and clinical site practitioner (CSP) would require if the CEWS hit a score of five plus. This included the situation, background, assessment, recommendation and decision (SBARD).
- Some nursing staff reported that they had found a few doctors were slower in accepting a child required palliative care support. This could prolong unnecessary interventions. However the senior nursing staff told us they felt confident to suggest to a doctor who may not recognise the need for palliative care to seek opinions from other colleagues.
- Nursing staff told us there was a clear plan of care to follow and the palliative care consultants worked together to support the family and ward staff. Records showed clear discussions with parents regarding the best interest of their child in the event of cardiac and/or respiratory deterioration.
- The trust's CSP team responded to all cardiac and respiratory arrests within the hospital. They held clear information on children for whom a do not attempt cardio pulmonary resuscitation (DNACPR) order was in place.
- Cases were presented to the trust ethics committee where there was a difference in opinion of what was best for the child. For example a parent may disagree with a clinical opinion that it was not in the best interest of the child to be resuscitated due to their life limiting

# End of life care

condition(s). Some cases were taken to court for a Judge's decision when a consensus could not be made through the ethics committee. These cases however were rare.

- Parents told us they had the confidence to make safe decisions about their child's care at home due to the support and training the PCT gave in recognising concerns and reacting to them appropriately, for example in how to support a child who maybe choking due to not being able to swallow or a child in pain.

## Handover

- All medical staff were aware of the status of the children the PCT were supporting within GOSH or in the community.
- We observed clear handovers within the hospital teams for patients who were admitted and for patients being supported within the community in and out of hours.
- The hospital's CSPs handed over between the day and night shift every morning and evening. They had oversight of all children of concern admitted to GOSH.
- Each morning at 8 a.m. the whole PCT received an email from the overnight on-call team member. The duty on-call doctor and nurse for the day followed up any on-going issues that required action.
- At the end of the day the duty PCT on-call doctor or nurse emailed the out of hour's on-call staff member about any patient changes that may be of concern over night or over the weekend.

## Nursing staffing

- There was 1.0 whole time equivalent (WTE) nurse consultant, 1.0WTE clinical nurse specialist (CNS) team lead, 4.7WTE CNSs and 1.0WTE specialist nurse which was a yearly rotational post. There was one vacancy. However this had been filled and they were due to start in June.
- The pain control team consisted of: 5.5WTE (6 nurses). Cover was provided from 8 a.m. to 8 p.m. weekdays and 8 a.m. to 3 p.m. on Saturdays. There was anaesthetist and CSP cover out of hours.
- There were 2WTE family liaison nurses located in the paediatric intensive care unit. There had been a recent reduction in the number of these nurses due to budget constraints. These nurse helped families of children coming to the end of their life with all aspects of bereavement support, this included psychological and

social support. They described themselves as the "eyes and ears of the team and the glue that holds the team together" during a difficult time. Other nursing staff commented on how valuable this role was.

- The family liaison role had been removed from the cardio intensive care unit and staff commented on how the support they provided to children, families and staff was missed.

## Medical staffing

- There were 2.5WTE medical consultants, 1.0WTE Associate specialist, 1.0WTE National GRID\* trainee and 1.0WTE London deanery trainee. One consultant had been on long term sick leave and therefore locum cover had not been arranged as staff managed to support the extra work load between them. This was causing some pressure on staff to maintain the level of work between them.
- On-call consultants were contracted to be available to attend GOSH as required.

\* National GRID training is for trainee doctors who wish to subspecialise in a specific area of paediatrics.

## Psychosocial Services

- The team had support from 1.0WTE clinical psychologist, 0.2WTE social worker and 0.5WTE family support worker.

## Support Staff

- The PCT had a 0.8WTE database manager. They were responsible for the creation of the palliative care and oncology outreach service's electronic recording system. The team spoke highly of the database manager and the system they had created.
- The team had 2.0WTE medical PAs and a 0.4WTE administrator.

## Mortuary staff

There were 2.0 WTE mortuary technicians. We were told there was a 50% vacancy rate and the administrative post for this service had been frozen. This was causing a backlog in some areas of their work, such as day-to-day administration, as the staff prioritised the care of the children and families.

We raised these issues with the trust including the cleaning of the post mortem room following a late night post mortem conducted to comply with religious burial

# End of life care

requirements. The trust ordered an immediate deep clean but went further to examine ways to improve support for staff. This resulted in an action plan which included more regular deep cleans and cleaning audits, more efficient removal of waste and cleaning of patient's clothes as well as recruiting additional staff by filling vacancies and setting up monthly quality assurance meetings in this area.

## Are end of life care services effective?

Outstanding



We rated end of life care outstanding for providing effective care.

There is a lack of nationally agreed audits and outcome measures for paediatric palliative care. A national data set would allow hospitals to measure their effectiveness of their care and patient outcomes against organisations of a similar standing. However we found the trust was actively engaged in monitoring and improving quality and outcomes locally and participated in national benchmarking, teaching and research opportunities. A dedicated team of researchers worked alongside the PCT and were collating information that sought to improve and advance clinical practice and policy.

Parents spoke very positively about the effectiveness of the care that their children were receiving. One family told us they thought the care and support they received through GOSH had improved the quality of their child's life and had extended the time they had lived for.

We saw evidence of a holistic approach to assessing, planning and delivering care and treatment to children and young people receiving EOLC. They used safe and innovative approaches to care. Staff worked collaboratively within the hospital and community.

### Evidence-based care and treatment

- Meeting minutes showed discussions around the National Institute for Health and Care Excellence (NICE) developing end of life guidance for babies, children and young people age 0 to 24. The anticipated date for publication was still to be confirmed. Staff were directed to the scoping document which was out for consultation in October 2014.
- We reviewed the draft document 'End of life care planning' which was waiting to be signed off prior to implementation in April 2015. The guide aimed to provide practical support for GOSH managers and clinicians. It identified their roles and the responsibility this held for improving EOLC in hospital and at home if it was the C&YP and parents preferred choice. The document referenced other resources available such as the Gold Standards Framework, the Together for Short Lives Core Pathway and the National End of Life Care Programme where e-learning modules for all levels were available.
- The PCT referred to core standard pathways for cases referred to them. These were generally based on the 'Together for Short Lives' standards. Where there was no standard to base it on, such as the antenatal pathway for babies with palliative care needs, the team had created their own pathway based on the Together for Short Lives Core Pathway.
- The PCT used a range of medicine reference sources to ascertain the best medication for a child based on their individual circumstances at the time. For example ibuprofen and paracetamol is contraindicated for haematology patients due to immunosuppression, however at the end of life it maybe in the best interest of the child to take it for pain relief.

### Pain relief

- The hospital used a tool to assess pain. Medical notes showed good records and appropriate actions taken in response to pain triggers.
- GOSH had a dedicated pain team. They offered advice and support to staff and families for children who were in acute chronic pain and/or required anticipatory pain management plans. This included liaising with the local teams as well as working with the PCT to support children being cared for at home, hospice and local hospitals.
- The PCT discussed children's pain management plans with the pain team each morning. We observed a meeting and found the conversations were child focussed and sensitive. They included a lot of thought about how to improve the quality of a child's life by safe alteration of medication regimes and equipment to allow for children to go out and anticipatory plans for weekends.
- Staff were very aware of how distraction could help with pain relief. Massage therapy was found to give a child a



# End of life care

sense of control over their symptoms and could be used as a tool to provide symptom management. The trust reported there had been significant feedback from C&YP, parents and staff on the benefit of massage therapy in pain relief.

- We saw robust conversations between the MDT about different medications available. There was a clear opportunity to challenge each other's thinking until a consensus was reached.
- Patient controlled analgesic was available for children at home.

## Patient outcomes

- The trust had systems that ensured timely identification of C&YP who moved from active treatment to palliation. The annual audit demonstrated that the PCT had an awareness of most children with palliative care needs within the hospital, this was with the exception of the critical care units who the PCT said "could provide end of life care very well."
- From 1 January to 31 December 2014, there were 99 anticipated deaths at the hospital. 23 died while admitted to the general wards, 41 died on the paediatric intensive care unit (PICU), 13 died on neonatal intensive care unit (NICU) and 19 died on the cardiac intensive care unit (CICU). Two died after transfer from PICU to a local hospice and home and one died during transfer from PICU to hospice (this was an expected death).
- 2014 data showed non-critical care wards referred 96% of expected deaths to the PCT, PICU referred 47%, NICU referred 12% and CICU referred 35%.
- GOSH PCT had started to use their own database to measuring outcomes for C&YP before, during and after death. For example they had audited whether preferred place of death had been discussed with patients/families and where it had the percentage of children and young people who had died where they wished to.

## Competent staff

- End of life and palliative care information was given to all staff on their induction course.
- Nursing staff told us they felt supported and had opportunities to develop their skill base.
- There were no official ward link nurses for EOLC however there were some enthusiastic individuals who championed the subject.
- Junior doctors across the trust reported feeling supported when looking after a child who is at end of

life. They were aware of possible complications and spoke confidently about their approach. They told us it was easy to access senior medical advice when required.

- Junior medical staff in palliative care spoke positively of their training within palliative care. They told us they were supported by the consultant and team which contributed to the breadth of their learning experience and increase in confidence.
- The PCT were encouraged to access clinical supervision on a monthly basis with the option for more frequent sessions if desired. Staff reported their supervision sessions as beneficial.
- Reflective practice sessions facilitated by the psychology team were available for senior staff (Band 7 and doctors). They were asked to commit to six sessions over six months. Any learning was shared with the management team with the permission of the participants. Staff reported positively about these sessions saying the peer to peer support was invaluable.

## Multidisciplinary working

- Weekly MDT meetings took place. They included the palliative care/end of life care team, and representatives from psychology, the research team, hospices, social work, University College London Hospital (UCLH), chaplaincy and administration as required. All complex and unstable patients under their care were discussed. They also discussed new patients and first assessments, these discussions were clearly documented within the clinical notes and available to the team 24/7 both within GOSH and by remote access.
- Every two weeks deaths of children who had been treated at GOSH were discussed and the bereavement lead attended these meetings.
- Internal audits were presented to the team every two weeks prior to the MDT meeting and outcomes, learning and interventions were decided and discussed.
- Pre-brief meetings co-ordinated by psychologists and the PCT helped staff manage difficult situations and/or prepare for a child's death. We observed a pre-brief meeting which related to very difficult end of life situation complicated by significant social issues. We witnessed outstanding leadership from the ward sister. They clearly articulated the need for the team to understanding the symptom management plan and level of support at the end of life in order to provide the

# End of life care

best possible care for the child and family. Staff valued these meetings as they were involved in the care planning and received emotional and practical support while caring for the child and their family.

- The value of the pre-briefs was measured through an anonymous feedback form.
- Cardiac children were often referred at the antenatal stage of pregnancy from a cardiologist who ran a clinic at University College London (UCL) Hospital. If a patient continued with their pregnancy the PCT worked with the cardiologist to determine the right level of care and intervention for the family.
- The chaplaincy played a key part in MDT meetings. They were invited by different teams at GOSH to take part in meetings where significant news was being shared with a child or family.
- The cardiac intensive care unit (CICU) spoke positively about the PCT support for families and CICU's needs as well as the pre-brief MDT meetings. They told us they were impressed by the PCT's innovation and ability to respond in a timely manner (same day) and discharge children home or to a hospice if it was the families' wishes.
- The PCT's associate specialist attended the daily intensive therapy unit's (ITU) ward rounds. This meant ITU staff had regular input from the PCT and consequently felt able to support C&YP and their families through EOLC.
- GOSH had service level agreements (SLAs) with the hospices and Life force community team. These were set up to improve joint working and continuity for the families, as well as addressing the need for specialist palliative care support for the hospices. The support included: review of hospice in-patients where required and for end of life care (including symptom management and advance care planning), attendance at panels, support for clinical governance, input into education and training, clinical supervision when requested. Examples of this were regular clinical supervision with Life force, and supervision for nursing staff to complete nurse prescribing course.
- The team liaised with the London Ambulance Service to discuss patient's resuscitation status, preferred place of death and management plans to avoid unnecessary and unwanted transfer to hospital. We saw an example of an ambulance directive in medical records.
- The team provided a face-to-face visiting service five days per week between 8am and 6pm and telephone advice 24 hours a day, seven days a week.
- Parents were provided with a telephone number to call. Calls were filtered and triaged by a CNS or specialist registrar (SpR) and supported by the attending consultant for that day.
- Parents reported no problems using the on-call service during normal hours as they could contact the team directly during weekdays. However outside of these hours the GOSH switchboard took the callers details and forwarded the information to the on-call CNS to follow up. Parents were told to expect their call returned within ten to 15 minutes and if this did not happen to call again. Parents we spoke with told us calls were usually returned within this time. However we were told it could be frustrating leaving contact details and the concern with the switchboard staff. One family told us they had to explain who the palliative care team were as some staff were not always aware of what the PCT did and therefore the nature of the call and urgency. They had found this frustrating particularly in the early hours of the morning when their child had difficulties and could be dying.
- Pharmacy support was available 24 hours a day and was provided by the main hospital pharmacy through a system of resident on-site staff. It was recognised there was a lack of specialist pharmacy support for C&YP receiving EOLC/palliative care.
- The chaplaincy service was available every day of the year, 24 hours a day. The team ran an on-call out-of-hours service.

## Access to information

- The PCT had remote access to emails through a mobile smart phone when outside of the trust location. All clinical members of the PCT could access electronic records for patients under their care through a remote access portal.
- The PCT liaised with GPs, hospices, community nurses and other people involved in a child's care when a child was transferred for care outside of GOSH.
- Each ward had a 'when a child dies' folder or box for staff to refer to. It contained practical information such as how to write a death certificate or refer to a coroner. Ward staff we spoke with were aware of these boxes/files and where to locate them and found them to be helpful.

## Seven-day services

# End of life care

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

- 2014 audits showed that resuscitation status was clearly identified in all the PCT's notes; this was an improvement on the previous year's figure of 92%. We looked at six DNACPR orders and found they were completed appropriately.
- The ethics committee were involved when there was a difference in opinion between medical staff, C&YP and or/their parents. The ethics service enables resolution without going to court.
- We spoke with one family who told us they had revoked their child's do not attempt resuscitation status due to personal concerns. This was accepted by the staff without judgement. A meeting with the ethics committee was arranged with the clinical team and parents to discuss and agree an appropriate course of action. The parent we spoke with felt this was an appropriate course of action and said "the process was not too daunting." However they told us they were surprised they had not received any written feedback from the meeting and had only a verbal response.

## Are end of life care services caring?

Outstanding



We rated end of life services as outstanding for caring.

Staff at Great Ormond Street Hospital showed exceptional respect and valued children and young people as individuals. Parents and other carers were empowered as partners in the child's care.

We found staff provided very compassionate EOLC to C&YP. Staff were committed to providing good care to C&YP that focussed on the parents and other carers gaining confidence in supporting children and providing the best quality of life possible.

During our inspection we spoke with parents of children who had received support in the hospital from wards staff and/or the PCT and to parents supported by the PCT in their own home. The parents we spoke with described the care and support all staff at the hospital gave as "outstanding".

The palliative care team was described as "phenomenal", "amazing" and "incredibly caring". We were consistently

told the team "went above and beyond" what was expected of them. We read emails from other medical professionals who described the team as "exceptional", "admirable", "patient", "supportive", "thorough" and "compassionate".

## Compassionate care

- During our inspection we saw patients being treated with compassion, dignity and respect. One family wrote, "we would like to express our sincere gratitude for the compassion and care you all have given our [child]. The care you gave at GOSH and at home was exemplary."
- Thank you letters and cards showed how much C&YP's families valued the support, advice and care that the PCT and ward staff gave to them. One email read, "[the palliative care consultant] is a hero...the nurses on Koala [ward] are magnificent."
- All staff we spoke with were passionate about how they cared and supported children and their families. We observed the 'at night handover between the CSPs. They clearly knew the C&YP they were discussing. We noted that the CSPs were able to describe the child's conditions, activities they had enjoyed during the day and as well as their physical and emotional appearance without continually referring to notes.
- The palliative care consultant sent a personal email to parents of children who had been under the PCT's care at the anniversary of their death. Responses from parents showed they were touched that they were still remembered. One parent said, "[the consultant] goes above and beyond, we have often had emails checking how we are."
- A condolence letter was sent from the trust's executive team with a support letter from the bereavement team to parents/carers two weeks after the death of a child to enquire about their wellbeing and offer any further support. They sent 'thinking of you' cards to parents for two years after the death of their child. As a result parents often wrote back to let staff know they valued being thought of and shared news.
- Parents told us they were able to stay for as long as they wished. Accommodation was arranged at the hospital for those who required it.
- It was clear from our discussions with mortuary staff that they cared deeply about treating each deceased

# End of life care

child that came into their care compassionately. They family's best interests at heart and discreetly supported parents throughout their visit(s) to the mortuary to see their child.

- It was also clear from speaking with staff that all staff at the hospital displayed compassionate care. We were told of a story where a member of domestic staff had found a small ribbon from a child who had been moved from a general ward to a critical care unit as their health had deteriorated, The member of staff sought out the family to return the small ribbon to them as they realised it may be important for the family to have as a keepsake.

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

- Medical records showed that conversations regarding end of life care had taken place between healthcare professionals, children where appropriate and their parents. Care plans were discussed with parents. This included their preferred place of care/death.
- The parents we spoke with told us they felt completely involved in care planning and supported in caring for their child. One parent told us, "we were first time parents which was daunting enough, but being first time parents for a very sick child was overwhelming. The guidance we received meant we could give our child an amazing quality of life and make them as comfortable as they could be at home."
- The PCT described ways in which they supported all the people and organisations involved in supporting a child or young person with life limiting or life threatening illnesses. As well as the child's family it included their school, emergency ambulance services, community nurses, GPs and community pharmacists.
- Play specialists supported siblings and other children through exploring their thoughts and understanding what their brother/sister/ friend was experiencing.

## Emotional support

- The families we spoke with could not praise the PCT highly enough for the emotional support they gave them. One parent said they were not only doctors and nurses but counsellors too.
- Emotional support was provided by the clinical psychologists within the end of life care multidisciplinary team.

- A family support worker and social worker were available as part of the EoLC multi-disciplinary team to provide families with practical support such as applying for grants and education. Families said this support was invaluable as it took the worry away and allowed them to seek help from sources they were unaware of, such as getting grants for equipment.
- The parents who received palliative care were highly complementary about the emotional support the team provided, and in particular the reassurance the lead consultant for end of life care gave. One parent said, "they were amazing, we had very dark moments and [the consultant] was a fabulous support. They gave realistic advice and handled end of life care plans wonderfully."
- Parents told us they were encouraged to take breaks from looking after their child in the hospital or through hospice respite for families supporting C&YP at home. This allowed them to gain support from other family members and friends and have 'normal' family time with their other children.
- There was access to multi-faith chaplaincy. We spoke with the team who were clearly intuitive, caring and open to anyone who wished to visit, whether they had a religious belief or not. One chaplain told us about their experience with a child who explored what death meant through visualising what was behind the black door in the chapel. This had taught the chaplain to be open and explore what was behind people's questions rather than answering the question for what it was.
- The child death helpline, jointly run with Alder Hey, was available for bereaved parents. This was staffed by parents who had also lost a child and had been trained to provide emotional support.

## Are end of life care services responsive?

Outstanding



We rated end of life care services outstanding for responsiveness to patient needs.

We found EOLC and palliative care was embedded in all clinical areas of the hospital and not seen as the sole responsibility of the PCT. It was tailored to meet the needs of individual children, young people and their families. It was delivered in a way that ensured flexibility, choice and continuity of care.

# End of life care

We found the staff constantly strove to meet families' individual needs. They were consciously aware of how their needs could alter with a change in their child's health and care needs. A parent we spoke with told us they received "bespoke care and never felt like they were nagging or asking too much."

The involvement of other organisations and the local community was integral to how the services were planned and ensured they meet the needs of the children and their families'. Community colleagues wrote "[your] contribution has been invaluable and timely and we could not have managed to provide the standard that we have aimed to without [your] support." Another team wrote, "thank you for supporting [a child] and [their] family in end of life care so professionally and at such short notice."

## Service planning and delivery to meet the needs of people

- The PCT provided tertiary specialist paediatric palliative care across the paediatric spectrum from the antenatal period, through infancy and childhood and also for young people up until their 19th birthday. Patients were transitioned to adult services by 18 years but the palliative care team worked alongside adult services until the young person reached 19 years. This enabled the young person and family to develop relationships with adult teams and services and avoided a sudden change of services if a young person was reaching the end of their life aged 18-19 years.
- The palliative and end of life care team supported the needs of children and their families across the United Kingdom as well as world-wide. They took into consideration the needs of each individual family and worked hard in supporting them in the community or at their local hospital. Whilst all young people transitioned to adult services by 18 years, the community support extended to 19 years, working alongside and jointly with adult services, to enable families to receive support from a familiar team whilst learning to navigate new adult services.
- The PCT saw 381 C&YP in 2013/14. 147 were palliative non-malignant cases and 40 were for palliative malignant cases. 194 were for the haematology/oncology outreach service.
- The PCT undertook over 2500 patient visits in 2013/14. Approximately 1200 were to GOSH inpatients, 80 to hospices, 600 for hospital outreach and 700 to C&YP's homes.
- During April 2014 to March 2015 the PCT provided paediatric palliative education courses focusing on developing knowledge and skills for 150 nurse and 120 GPs across London through a programme of face-to-face and on-line training. The course evaluation showed a significant increase in the participants' skills, knowledge and confidence after attendance.

## Meeting people's individual needs

- We found all staff were sensitive to individual needs, this was apparent across the whole of the hospital. We were given many examples of how families were supported in providing quality of life for children who were actively dying. This included days out of the hospital or home, arranging celebrity and animal visits, hospice respite, funding/grant support, and normal activities such as breast feeding their baby and taking their child to a local park.
- Children and their parents were supported in choosing their preferred place to die. Staff told us how the PCT supported parents in choosing a hospice the family had felt reassured by the continuity of care. Another family told us it was their decision to stay at GOSH until their child died. They had been offered support from the PCT; however the family felt comfortable with the ward staff's support and did not wish to introduce more people in the last days of their child's life.
- We observed staff were patient focussed and considered each individual's needs. For example staff recognised that a child to be allowed to be awake and playing at 3am in the morning was not the 'norm' however it was acceptable for someone who was at the end of their life.
- The team spoke passionately about "releasing children from the burden of palliative care" if they reached a stage where their condition although not curative was stable or waiting for organ donation. They felt it was important for C&YP to be released from regular palliative care appointments if they were not actively dying or if their care needs did not require ongoing specialist support.
- Staff gave consideration to parents and children who had learning difficulties. We were told about a parent who had learning difficulties and was unable to use the



# End of life care

memory box usually given to parents to remember their child. Staff had found they were able to connect with the mother and her memories of her child through arts and crafts. They had also used this approach for people who could not understand English.

- Another family told us of how the team helped them make difficult decisions relating to their child's treatment which conflicted with their religious beliefs. Discussions were held with the family, the PCT, community paediatric consultants and the family's religious leader to find a way that supported their child without conflicting with their customs.
- The same family told us who they were supported in a non-judgemental way in their decision to celebrate their religious holiday at home while their child remained in hospital. Over this period they also found a way to communicate daily with the family without breaking their religious practices.
- Siblings were supported at the hospital by play workers. A family spoke positively of this support, especially at the weekends when the whole family were at the hospital. The play workers not only supported siblings in activities but were able to help children explore and figure out their own feelings, and help them understand what their relative was experiencing, as well as explore what dying and death meant.
- On the day of our inspection the GOSH PCT had started an outpatient clinic at one hospice and were starting one at another hospice in May 2015. These were set up to increase patient/parent choice in where they were seen and to provide a MDT review closer to home. The outcome for children and their families using these clinics was being evaluated over the coming months.
- We observed an example in medical records of a conversation held through an interpreter when discussing a child's life limiting illness with a family who did not understand English.
- There was access to a large number of leaflets and age specific books to support C&YP, parents, siblings and schools in EOLC.
- Age specific books/literature explaining specific illnesses such as cancer and what EOLC means was available for adults to support them in explaining a child or young person's illness and prognosis. These could be used with children in schools or with siblings.
- One parent we spoke with told us they would have liked to have received information/guidance on how to support a child when they were actively dying. They

appreciated that it may not be usual for parents to want to know what to expect when a child dies, however they felt it could be offered and maybe useful especially for parents supporting a child at home. They were unaware of ways in which they could have supported their child during the dying phase and felt they could have made them more comfortable had they know certain things, such as changing the position of their bed.

- Colour coded bottles and syringes for accurate measurement of medicines were used for family members that could not read.
- The PCT's involvement did not finish once the child had died. They supported families in the practicalities after death. We were given an example of a deceased child who had a complicated travel itinerary to be repatriated back to their home country and another example of a deceased child transferred to a hospice with a cool room after death so their parents could spend time with them.
- The PICU had secured a dedicated side room for children reaching the end of their life. This room was appropriately appointed to support babies, children or young people and their families. This offered them a private space to spend time together. The room was decorated in neutral colours, had comfortable seating and refreshments available. The room could be cooled to allow family members to stay with the deceased for longer.
- Children's bodies were always taken to the mortuary by nursing staff who knew the child. Porters were not asked to attend to C&YP. Babies were carefully wrapped and carried to the mortuary in their arms. Larger children were taken to the mortuary via a dedicated lift.
- The mortuary was located in the basement area. We found the entrance to be discreet and the waiting area clean and tidy; children's toys were available for siblings. The area was decorated in neutral tones with no religious symbols which allowed them to accommodate all faiths. The viewing room had a normal bed for children to be laid in and a Moses basket for babies. There was a compact disk player and 'soft' music was played during a viewing, families were also encouraged to bring music of their choice.
- The chaplaincy was a multi-faith team. Each Tuesday they held a coffee morning for anyone who wished to visit the chapel/ multi-faith area in the hospital. They



# End of life care

also put on a service of thanksgiving and remembrance on the last Saturday in April every year. This was open to anyone who had lost a child at GOSH and for staff. About 400 people attend the service each year.

- Services for other faiths were also held.
- There was a Christian chapel which was described by the chaplaincy as a “Victorian sensory room” due to the vibrant decoration, gilt edging, paintings and stained glass windows. The pews were designed for children’s height. There was a large quantity of soft toys and around the chapel. Parents were encouraged to complete a tag for any toys they left so the chaplaincy could track them and return them to parents if they wished. They were in discussion as to how to manage the large number of toys in the future.
- There was a multi-faith room used as the Muslim prayer room. However it was not fit for purpose as it had no running water and no clear separation for male and female sections. A proposal had been put to the board to accommodate changes, but it had yet to be approved at the time of inspection.
- There was a Shabbat room for the Jewish community. This was maintained by a local Jewish charity. This space was appropriate for prayer, rest and for eating and much appreciated by the Jewish community..

## Access and flow

- Any member of staff in the hospital or community or a parent could refer a patient to the GOSH PCT. If the child met the criteria for referral the team would either support the child, family and staff. Where the family did not wish for palliative care involvement the team provided advice/support to the clinical staff caring for the child and their family. The PCT supported C&YP within GOSH, local hospitals, at home or in hospices.
- The team responded to urgent referrals within 24 hours and non-urgent referrals within 48 hours.
- For children and young people receiving EOLC the preferred place of death was discussed and achieved for 44% (7 out of 16) of children who were admitted to PICU, 100% for children admitted to NICU, 33% for children admitted to CICU. 68% of C&YP admitted to non-critical care wards were offered a choice in place of death and 73% (11 out of 15) of those achieved their preferred place of death. The trust audited the reasons for discussions not taking place or not achieving preferred

place of death. These included, parents not wishing to discuss their child’s death, rapid deterioration, child too ill to move choice not available as complex overseas needs.

- Access to the mortuary was by appointment only. Staff told us they were able to accommodate unexpected visits within a short space of time if necessary. Appointments were allocated for an hour, although visitors could stay longer if they wished.

## Learning from complaints and concerns

- The PCT had not received any formal complaints over the last five years. However they were still able to recall the learning points from the complaint from five years previously which showed that learning from complaints was embedded.
- Staff told us they dealt with any concerns as they arose which may account for few official complaints relating to EOLC.
- Parents we spoke with told us they had no reason to complain about the service but had they needed to they felt it would have been dealt with appropriately.

## Are end of life care services well-led?

Outstanding



We rated leadership in end of life services outstanding.

The end of life team said “we all want to deliver safe and compassionate care that’s delivered in the right place for that family.” There was a clear structure and each team member’s responsibility and expectations was laid down in a clear operational policy.

We found the leads for palliative care, end of life and bereavement services to be humble and modest when describing their team’s work. They came across as ‘just doing their job’ and not doing anything ‘special’. However, the parents we spoke with told us all the staff at GOSH were “amazing” however there was something “extraordinary” about the PCT. Parents intimated that the leadership at a local level contributed hugely to creating a consistent and competent team as they led by example and went that extra mile.

We were impressed with the team’s recognition that the service they provided could always be improved. They were constantly raising their own bar to drive and improve the

# End of life care

delivery of high quality person-centred care. The palliative care, end of life care and bereavement leads were not afraid to try new things, evaluate and then abandon them and consider different options if it was found ineffective or unsuitable.

## Vision and strategy for this service

- The PCT's strategy and vision was to provide the best palliative care to every C&YP under their care who had life limiting / life threatening conditions. This was from the time of diagnosis or recognition that a condition was likely to mean that a child or young person would not survive into adulthood.
- They wholly believed that the best care was achieved through a multidisciplinary network approach. This allowed each C&YP to access a full range of services to address all emotional, psychological, medical and practical needs, which was equitable and individualised and provided in the place of choice all supported by suitably trained staff.
- The PCT were clear that EOL and palliative care was 'everyone's' business'. They saw their role as supporting and empowering ward staff to deliver good EOLC. They said, "the ward staff want to get it right."

## Governance, risk management and quality measurement

- The PCT and oncology outreach was managed within the infection cancer, immunity and laboratory medicine (ICI-LM) division of the trust. The services operational policy included the service profile, mission statement and objectives for the palliative care and oncology outreach team. This included staff responsibilities and expectations, key relationships with other providers, service level agreement details and where to access key policies and procedures.
- The speciality management team met on a monthly basis to ensure standards were met and to provide strategic and financial planning. This team included the head of service/nurse consultant, general manager, team leader (CNS) and clinical chair from UCL. The head of service reported to the divisional director through the monthly ICI-LM board meeting.
- The senior clinical team met weekly to discuss clinical cover, support, supervision and education for junior doctors and CNSs, incidents and complaints over the

week and the integration of research. This team was made up of the head of service, medical consultants, associate specialist and CNS team lead. The clinical chair joined one meeting per month.

- The EOLC Group met four times a year. Minutes of the meetings showed discussions relating to incidents, audits, outcomes and learning.
- The PCT data management allowed them to provide activity logs for commissioners of the service, draft policy for bids and provided data for presentations.
- We found the team monitored the provision of their service and reviewed ways in which to improve.
- The bereavement suite and mortuary service was part of ICI-LM division which was led by a divisional director.

## Leadership of service

- Staff spoke of an open leadership culture. We found the PCT to have a flattened hierarchy where everyone's opinion and thoughts were valued.
- The end of life care and palliative care leads were passionate and caring about the service they provided, their staff, the C&YP and parents they supported. Parents told us they trusted the whole team and had every confidence in their ability due to the leadership of the PCT.
- All staff we spoke with felt their line managers and senior managers were approachable and supportive. Staff told us the trust leaders had an open door policy and they felt comfortable approaching the most senior staff.
- Staff on the wards were able to name members of the PCT and give examples of their involvement in optimising C&YPs' care.

## Culture within the service

- We found staff across the whole hospital saw EoLC as the responsibility of all and did not fall solely on the palliative care team.
- Staff were sensitive to parents' reasoning when their child was actively dying. For example some parents felt having senior staff involvement could prolong their child's life. One ward manager told us that although there were very few deaths on their ward they ensured senior staff were involved to provide experienced nursing support to junior staff and reassurance of the best medical expertise for the family.
- There was a slight perception from junior staff that staff "higher up" in GOSH thought children should be at

# End of life care

home or in a hospice at the end of their life in order to free up a bed and reduce costs. This perception was echoed by a parent we spoke with. Ward staff thought it was appropriate for some families for their child to die in the hospital and felt able to judge when it was fitting to support the family's wishes in this way.

## **Public, staff and other healthcare professionals engagement**






- The palliative care team recruited an associate specialist who attended the critical care ward rounds to provide palliative advice and input if it was thought the child would benefit any further from the service. Staff reported positively about this role and told us it helped them support C&YP with confidence.
- Psychological support was available for the palliative care team, however staff on the wards reported emotional support was variable. They thought this could be due to the small number of deaths on the wards.
- The PCT had taught at the neonatal units of other trusts to raise awareness of determining the right level of care and intervention for babies born with life limiting/threatening illnesses.
- The team ran a visitors programme providing education opportunities to healthcare professionals in the UK and internationally.
- They held 1-2 visitors afternoons every year for professionals from GOSH and other healthcare organisations to find out more about the team and palliative care.
- The service invited patient and public involvement through annual engagement activities, satisfaction surveys, bereavement days, audits, research projects and support groups.

## **Innovation, improvement and sustainability**

- The EOLC and palliative care leads were committed to and passionate about improving the service they provided. They said, "it's like the M25, it never ends."
- The death of each child at GOSH was discussed at the mortality and review group. Senior members of the hospital team reviewed notes for accuracy, communication and appropriate care by appropriate staff. Any concerns and learning was shared with all teams through LIMB.

- There is a lack of nationally agreed audits and outcome measures for paediatric EOLC. We were told the Trust was keen on benchmarking and found it frustrating that Public Health England was not transferring information collected by children's services into a national data set. A national data set would allow hospitals to measure their effectiveness of their care and patient outcomes against organisations of a similar standing.
- GOSH PCT had started to use their own database to measuring outcomes for C&YP before, during and after death. For example they had audited whether preferred place of death had been discussed with patients/families and where it had the percentage of children and young people who had died where they wished to.
- Internal audits were presented to the team every two weeks prior to the MDT meeting and outcomes, learning and interventions were decided and discussed.
- The trust took part in research into pain and palliative care through the National Institute for Health Research, Clinical Research Network – Children. This study included the effectiveness of different symptom control medications for various medical conditions across age ranges, the study also included massage therapy as a form of pain relief/distraction.
- Leads told us that, at a time of financial constraint, there had been commitment to invest and expand the EOLC/palliative care service. However two clinical papers ("An audit of compatibility of drug admixtures used for syringe drivers in paediatric palliative care" and "Pharmacy Impact on Medicine Management and Patient Safety in Paediatric Palliative Care") had identified a need for pharmacist support for palliative care at GOSH. Interviews with members of the PCT confirmed that, although some limited support was available, there was still a need for greater input. We found they were the only division in the hospital to not have specialist pharmacy input. A case had been put forward for a part-time post but that funding for this (which would be largely from charitable donations) was not yet available. The chief pharmacist confirmed that they were aware of this need and that it would be met if finance was available to cover the additional staff time needed.

# Outpatients and diagnostic imaging

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

## Information about the service

The outpatient and diagnostic imaging department provides outpatient clinics and diagnostic imaging services to children funded by the NHS and private funded patients from overseas and the UK. Outpatient and diagnostic services are provided in various settings throughout the main hospital site including main outpatients, nuclear medicine and various imaging suites. Outpatient services are also provided across three floors in a building that is on the main hospital site but in an area managed by another London trust and in the private Octav Botnar Wing.

The trust's outpatient department held clinics for a range of different specialities including orthopaedics, plastic surgery, ophthalmology, gastroenterology and ENT. The diagnostic and imaging department offer a range of services including Computerised Tomography(CT), Magnetic Resonance Imaging (MRI) and x-ray

During the period July 2013 to June 2014 the outpatient departments saw 233,462 new and first follow up attendances. We visited all the outpatient and diagnostic imaging departments. We spoke with 27 children, young people and parents / carers as well as with 65 members of staff. We observed care and treatment and looked at care records. Information provided by the hospital before the inspection was also reviewed.

## Summary of findings

There was a culture of high quality, child centred care delivered by competent staff. Effective systems were in place for reporting and investigating incidents. The learning from these investigations was used to change practice. The environment and clinical equipment were visibly clean and appropriately maintained. Medical records were available but they were not always transported using equipment that was suitably maintained.

There was participation in audits and care and treatment was provided in line with professional guidance. Staff had access to a range of mandatory training and professional development. While not all services operated seven days a week, services were flexible to meet patients' needs. There was evidence of multidisciplinary team working and systems were in place to coordinate care with other departments in the trust.

Children, young people and their parents received compassionate care and were encouraged to be involved in decisions about their treatment. Feedback was proactively sought to improve the service. Cancellations were minimal and appropriate action taken. However; delays in clinics were a routine occurrence and the action taken had not resolved the underlying issues. Informal and formal complaints were listened to and action taken to resolve the issue.

# Outpatients and diagnostic imaging

There was a vision and strategy for the development of the service. There was identified leadership who were supportive and motivated staff. Governance and risk management processes were embedded into practice and fit for purpose.

Following a review carried out by the intensive support team into referral to treatment (RTT) data including for patients in outpatients and diagnostic imaging, the initial findings were that the data was unreliable.

## Are outpatient and diagnostic imaging services safe?

Good



There were effective systems in place for reporting and investigating incidents and implementing learning into practice. The equipment used in the outpatient and diagnostic imaging department was visibly clean and appropriately maintained.

Resuscitation equipment was readily available to use in the event of an emergency. Medicines were stored and administered appropriately. However, interventional radiology lacked a suitable process for recording the disposal of controlled drugs. Medical records were available for outpatient appointments but they were not always transported between departments using equipment that was suitably maintained. All staff participated in mandatory training relevant to their role.

### Incidents

- There had been one surgical error and one serious incident reported within the outpatient and diagnostic imaging departments between February 2014 and January 2015.
- There had been no Radiation (Medical Exposure) Regulations (IR(ME)R) events in the last 12 months.
- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents using this system. A total of 33 incidents had been reported by outpatient staff in March 2015. These included incidents such as unauthorised members of the public on the premises and out of order lifts in one of the outpatient buildings.
- In the same period 30 incidents were reported by diagnostic imaging staff. These included problems in locating patient notes when moving between departments and the failure of equipment.
- Senior staff in radiology told us that they had encouraged staff to increase their reporting of minor concerns, which had resulted in improved practice.
- The sample of incident forms we reviewed showed identification of factors contributing to the incident. We



# Outpatients and diagnostic imaging

saw that in each case a manager had reviewed the incident and action had been recommended or taken to reduce the risk of a similar incident occurring in the future.

- The sister managing private and international outpatients told us that a 'daily huddle' took place each morning and that the potential for incidents based on the booked patients was discussed.
- Information relating to reported incidents was collated and discussed at the monthly risk meeting and the minutes of these meetings we saw confirmed that incidents were discussed and action points shared with staff via methods such as staff meetings and email bulletins.

## Cleanliness, infection control and hygiene

- Staff working in the outpatients and diagnostic imaging department understood their responsibilities in relation to cleaning and infection prevention and control. During our inspection we saw that staff understood how to keep areas clean and the actions to take to reduce the risk of infection such as use of personal protective equipment, including gloves and aprons..
- Many areas had recently changed to a 'visible cleaning' policy, rather than cleaning taking place at set times of the day. We saw that staff were proactive in maintaining the cleanliness of the busy waiting areas.
- There were infection control flowcharts for each area and we saw that staff followed these procedures appropriately.
- The clinics had isolation rooms and staff were able to explain and demonstrate in detail how these were decontaminated after each use.
- The latest monthly hand hygiene audit undertaken by the infection control team in main outpatients, showed the area's compliance with hand hygiene practices was 100%.
- There were enough hand washing facilities including hand wash basin and hand gel sanitizers within the clinics and imaging suites and we observed staff were compliant with appropriate hand hygiene practices between patients.
- We observed the play therapist cleaning toys in an outpatient waiting area, they showed us the cleaning checklist they used and also how toys from the isolation rooms were sent for decontamination in colour-coded bags.

## Environment and equipment

- The outpatient departments were child friendly, decorated in animal-related themes which made them more appealing and less intimidating to children and young people.
- We saw that waiting areas and clinical treatment areas were maintained to a high standard and staff understood their responsibilities in relation to appropriate maintenance.
- We observed some waiting areas were at risk of overcrowding, particularly in the safari outpatients. While we did not see evidence of an impact on the safety of people using the area it did become very warm and uncomfortable at times. Staff told us that they were concerned about the number of children and parents in the area at times and had introduced systems to manage this. These included children at risk of fitting if they became too hot being given a pager and only called into the department a short time prior to their appointment.
- The resuscitation trolleys in all areas we visited were in line with national resuscitation council's recommendations, had been checked daily and these checks recorded. All trolleys were situated in areas without obstruction and could be easily accessed. All the oxygen cylinders we checked were in date.
- The security staff we spoke with were able to show us how they maintained the safety of the environment, including the use of an extensive CCTV system, a robust intruder and abduction policy and regular risk management meetings.
- During our inspection there was a security incident in which an unauthorised member of the public gained inappropriate access to the building. We observed that the procedure for security staff to respond to this were fast and effective.
- Clinical and medical staff we spoke with in the various diagnostic imaging departments were aware of the procedures to follow in the event of equipment failure. The number of times this occurred was very low and had been reported as an incident and action had been taken to reduce the risk to patients.
- Staff in the medical records department told us that the process for transporting records was not fit for purpose as they often had to use trolleys that were damaged and



# Outpatients and diagnostic imaging

that records were transported outside across pavements and roads that were poorly surfaced. This arrangement could lead to records falling off the trolley and being damaged or staff injuring themselves.

- All equipment seen had been appropriately checked, cleaned and maintained. There were checklists which showed that daily checks such as calibration and physical cleanliness on all imaging equipment's had been completed. Portable appliance testing (PAT) was up to date and had been undertaken in the past twelve months.
- The imaging department manager told us all x-ray equipment such as computerised tomography was compliant with national guidelines and IR(ME)R 2000 regulations and that there were local rules in place to ensure safety standards were maintained.

## Medicines

- Staff were aware of medicine management policies and were able to tell us what they would do in the event of an error.
- We found that the interventional radiology department did not have an appropriate recording procedure in place for the disposal of controlled drugs, as there was no record of the disposal.
- We saw that imaging departments had procedures in place to ensure the safe dosage of radiation and that risk of excessive radiation were effectively managed.
- The parents we spoke with told us staff informed them about medication that had been given or prescribed for their child; this included how it should be administered.
- The majority of medicines used in the department were for pain relief or local anaesthetic. We noted that medicines were appropriately stored, checked and administered.
- Medicines requiring cool storage were stored appropriately in fridges and we observed that twice-daily fridge temperatures had been recorded. These recordings were within appropriate levels.

## Records

- The records' management policy stated that breaches of data protection would be dealt with using the trust's incident reporting system. Staff in the records department told us that such breaches were very rare and were able to explain how they worked to prevent this from happening.

- Information governance training was mandatory for all staff to ensure compliance with the Data Protection Act. The mandatory training records seen showed that the majority of staff had completed this training..
- At the time of inspection we saw patient personal information and medical records were managed and stored securely. However, staff reported some issues when transferring these to the clinics, these included having to take these outside the hospital in the rain and transporting notes on trolleys that were frequently not fit for purpose.
- The medical records department ensured records were prepared and delivered to each outpatient department, except private outpatients, prior to each clinic session. We observed records being transported on eight different occasions. In each case a single member of staff was responsible for these, including when transporting them outside along a road that was open to the public. Some staff told us that they felt vulnerable doing this alone.
- The private outpatients department had its own in-house records department. Staff told us that embassies were often responsible for sending medical records for international patients and that treatment would not be given until the clinician was satisfied that appropriate medical referral information had been received.
- Staff we spoke with told us the majority of records were available for appointments. A member of medical staff in the main outpatients told us that the only problems they experienced was when other clinicians did not return documents promptly. Another member of staff told us that two patients had been significantly delayed because healthcare assistants had sent records to the wrong doctor and that learning had taken place from this.
- We observed in the x-ray department that staff were proactive in ensuring the images they received when a patient was referred into the service were clear and accompanied by detailed medical notes.

## Safeguarding

- There was a safeguarding children's policy that reflected national guidance. All managers and staff we spoke with demonstrated an awareness of their responsibilities in relation to safeguarding.
- We saw evidence that staff acted immediately to respond to any safeguarding concerns by involving the

# Outpatients and diagnostic imaging

appropriate professionals. We were provided with an example of when staff had followed the hospital's safeguarding policy. This related to an incident when a parent turned up to collect their child under the influence of alcohol.

- Staff we spoke with in private outpatients told us that their safeguarding training was particularly in-depth as they often had to deal with situations involving problematic differences in cultural practices with international parents.
- Training records for all outpatients and diagnostic imaging departments showed that 100% of staff had attended safeguarding children training appropriate to their role.
- Practice educators told us that safeguarding was a regular feature of weekly education sessions and that there was a culture of openness in terms of staff requesting and receiving any additional training that they felt would be beneficial.
- Staff told us that the trust operated a useful e-learning system and that they had undertaken 'safeguarding children' learning before they started in their post.
- A student nurse told us that their initial training had been focused on safeguarding and whistleblowing and that they felt confident in raising any concerns.
- The educational facilitator for outpatients told us that clinical safeguarding supervision sessions took place regularly with a dedicated safeguarding nurse and social workers.
- All staff spoken with were aware of the hospital's whistleblowing policy. They told us that they would feel happy using this policy to raise concerns if necessary.

## Mandatory training

- There was a mandatory training policy that detailed which training staff were required to attend. The training included resuscitation, safeguarding, information governance, basic life support, risk assessment and health and safety and welfare training. We saw there was a mandatory training planner and the policy stated staff had weekly protected time and two days annually for training.
- The locally held mandatory training records we reviewed for the outpatient departments showed 100% of staff had completed the required mandatory training over the last 12 months. Staff we spoke with confirmed

they had attended mandatory training and in all cases staff told us that the quality of training was very high. A radiographer said, "I've never had training like it, they're really thorough and the educators are very patient."

- The dedicated outpatient educational facilitator ensured that mandatory training was up to date for all staff. They told us that weekly education sessions were protected so that all staff had the opportunity to attend. They also told us that annually staff were given two full days of protected time to make sure their mandatory training was up to date.
- Staff in the department said that their protected teaching time each week was very useful and that training such as life support and manual handling had improved the level of care they were able to give.
- Managers told us that they were happy that staff had sufficient time to complete their mandatory training and that they felt all staff were motivated and well trained.

## Assessing and responding to patient risk

- All staff we spoke with told us that they considered the risks to children and parents attending the department to be minimal and that these were closely monitored.
- There were clear procedures in place for the care of children who became acutely unwell. Staff we spoke with were aware of the emergency procedures that they should follow.
- Staff told us that they received referrals from a range of NHS trusts and embassies but often these did not include enough medical or clinical information. In outpatients we were told that 85% of patients who were referred were missing the minimum level of medical information. We found that staff managed this risk by proactively contacting the referring organisation to obtain the necessary information about the patient prior to treatment.
- All children known or considered to be at risk of being MRSA positive were taken directly into one of the isolation rooms when they arrived in the department to minimise the risk of cross infection. The department also had an established procedure for the management of patients suspected of having been in contact with Ebola.
- There were emergency assistance call bells in all patient areas including treatment rooms and the x-ray suite. During our inspection we noted some of the emergency call bells in main outpatients were not working.

# Outpatients and diagnostic imaging

correctly. Staff managed this risk by posting easy-to-read signs on the call bells with clear instructions about the procedure to follow in case of an emergency.

- Risks in radiology were understood and managed. Radiation protection monitoring at the hospital was in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) requirements. Where errors had taken place or a patient had been placed at risk, an external facilitator was used as part of a process of addressing the risk factors involved.

## Nursing and diagnostic imaging staffing

- The outpatients and diagnostic imaging department had a team that included registered nurses, healthcare assistants, radiographers, radiologists, receptionists and administration staff.
- The duty rotas for the three months prior to our inspection in the outpatients and diagnostic imaging departments we looked at showed that there had always been sufficient staff on duty in line with the department's agreed staffing establishment.
- Managers, nurses and other staff told us that although staffing level in some staff groups such as administration staff were not always at the level required the nursing teams were fully staffed.
- A healthcare assistant told us that low staffing and high levels of sickness meant that they were often put under excessive pressure. They told us that two healthcare assistants could often be responsible for 90 children and their parents waiting for appointments in six clinics at the same time. We observed that staffing levels in many of the outpatients and diagnostic imaging areas were low. Although staff were always visible, they were responsible for numerous children and their parents.
- The vacancy for nursing staff in interventional radiology was reported to be 38.5%. Staff in CT, MRI and x-ray told us that the current staffing levels meant it was difficult to meet the demands of the service but children were never put at risk as staff ensured their safety was the priority.
- Senior managers we spoke with said that the role of nursing staff was clearly defined and that they were satisfied that clinics and departments ran smoothly and safely as a result of this.
- Staffing levels in private outpatients were noted to be consistent. Managers, nurses and staff told us that they were happy with staffing levels and felt they met the

services needs. The parents of a child attending clinic said, "I've never felt that they're short staffed in here. They clearly work very hard but the level of service is fantastic."

- Retrospective exit interviews with private patient staff who had moved to another area in the hospital had been introduced to identify the reasons for moving to use this to improve conditions for existing staff.

## Medical staffing

- Medical staff in radiology told us that they felt staffing levels were adequate and that while the service was busy they were not short-staffed. They said they had time to spend with children and their parents, to talk to them and make them feel calm before they had any procedure.
- Most clinics were consultant led, for example in the main and private outpatients. Staff told us that the most of the consultants attended promptly for their clinics but there were some consultants who were frequently late for clinics.

## Major incident awareness and training

- The majority of staff we spoke with had a clear understanding of fire, emergency and evacuation policies and procedures. We found that emergency procedures, including the hospital major incident plan, had been tested in the best interests of patients, visitors and staff.
- As part of their fire training, staff had taken part in a simulated emergency using the trust's established emergency communication systems. A healthcare assistant told us that this had helped them to consolidate their learning from the fire lecture they had taken part in when they started working at the hospital.
- The lifts in the main outpatient's host hospital were known to be at risk of failure. Staff explained the contingency plan that was in place should the lifts fail so that they could continue to run clinics as far as possible without undue stress and disruption to patients.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services effective?

The service participated in audits and provided care and treatment in line with professional guidance. Care was delivered by staff who had access to a range of professional development training and who had participated in annual appraisals.

A multi-disciplinary team approach was taken across all the services provided from the outpatients and diagnostic imaging department. The outpatients department did not operate seven day services, however they had amended opening hours to minimise disruption during building working. Radiology services were available 24 hours a day, seven days a week.

### Evidence-based care and treatment

- The radiology functions of diagnostic imaging were accredited by The Royal College of Radiographer's Imaging Services Accreditation Scheme. A service manager told us that this had positively enhanced the provision of care and treatment.
- Staff we spoke with explained the evidence-based systems, such as the standard operating procedures that were in place to ensure procedures were undertaken in line with best practice.
- We found that diagnostic imaging staff had been actively involved in a programme to reduce the radiation dosage during chest CTs since January 2015. Staff told us that this programme had reduced radiation dosage during such procedures by 50%.
- Staff in interventional radiography used appropriate treatment checklists from the World Health Organisation, however, we were not provided with evidence that regular audits of these checklists took place.
- As many images were sent with patients from other hospitals, an imaging review board had been convened across radiology functions to improve the use of images received from outside the hospital which in line with best practice reduced the level of radiation exposure for children.
- Senior staff actively involved HCAs in auditing the quality of the service provided such as clinic waiting times. The findings of these audits were discussed at the

monthly staff meetings. Audit findings and changes made were included in the quality review documents which were shared with other departments, learning included strategies to reduce wait times.

- Safety alerts were received by the outpatient and diagnostic imaging managers and cascaded to the appropriate staff. We observed that safety alerts were displayed in staff rooms and shared at regular staff meetings.
- National guidelines for radiological reporting and the hospital's own quality standards for radiology practice were followed in relation to radiology activity and reporting. This included all images being quality checked by radiographers before the child left the department.

### Pain relief

- Children and young people had access to appropriate pain relief and local anaesthetic where necessary. Staff told us that children never experienced delays in obtaining this and they had access to the type of pain relief most appropriate for the age and condition, such as breathable pain relief.
- Dental staff told us that pain relief was offered appropriately and in a timely manner to children and young people when needed.
- We observed that staff were aware of when children and young people might be in pain and were proactive in offering medication while also explaining why and what drug was being given to parents appropriately.
- The imaging department had a stock of pain relief and local anaesthetic for use when invasive procedures were being carried out. We saw that pain relief was discussed with children and their parents during their consultation or treatment and analgesia was prescribed as necessary.

### Competent staff

- All new staff completed an induction programme to prepare them for their role. The head of nursing for outpatients told us that they had implemented a 'be the patient' session to the induction programme for all staff in the department. This session took staff through the various outpatient departments and trained to experience these as if they were a patient to help them understand the experience from another point of view.
- A range of education and learning sessions were available to assist all staff develop and maintain their

# Outpatients and diagnostic imaging

skills. All staff were encouraged and supported by senior staff to utilise these opportunities. For example, a healthcare assistant had been developed and trained as a team leader for the main outpatient's phlebotomy service. While several staff we spoke with told us their managers had supported them to pursue postgraduate qualifications in their specialty.

- Staff were provided with time to complete training. A new healthcare assistant told us that all staff were given education time in their weekly schedules and that there were additional clinical educator drop-in sessions in their departments. We saw a schedule for this training and noted that staff were able to make requests for specific topics and we saw these requests had been provided. For example, staff had requested and received training in treating children and young people with specific learning disabilities.
- All staff we spoke with were positive about the training and development opportunities given to them and the quality of this training. In radiology, a member of staff said, "the corporate induction was fantastic. The training has been really good and I've never felt like I've been left on my own."
- Experienced staff told us that they were buddied with new staff to ensure that people were comfortable and competent in their role.
- Radiation protection training for junior radiologists was not consistently provided. We were told that this was as some staff were on a short rotation and would only be at the hospital for three months and therefore were not provided with this training.
- Radiation protection training was provided four times per year to ensure staff were competent in this area of their work.
- The hospital used a team of volunteers to support the delivery of patient services. We saw that this helped to relieve pressure on staff and that volunteers had been appropriately trained and inducted. One volunteer we spoke with told us that they had received excellent training and support in their role and that the volunteer manager had been able to provide any extra training they needed.

## Multidisciplinary working

- Outpatients and diagnostic imaging departments supported multiple specialty clinics, staff told us that effective multidisciplinary working assisted with communication when transferring children between imaging services and main outpatients.
- The parents of a young person with complex needs told us that they were very happy with the way various specialists had worked together to provide treatment.
- We observed nursing staff worked well together as a team and providing support to ensure that care and treatment was managed effectively.
- Multi-disciplinary team (MDT) working was evident throughout the department with the majority of meetings such as the risk groups and the radiology steering group involving a range of allied health professionals, nurses and managers.
- The hospital psychologists and social workers were readily available to assist staff when needed and we noted that doctors, nurses and healthcare assistants were proactive in contacting them for support.
- There was consistent evidence of collaboration across different services within outpatients and diagnostic imaging. For example, volunteers, bank staff and administrators were all involved in staff meetings and staff considered that this ensured they worked more coherently together and felt valued.

## Seven-day services

- Seven day a week outpatient services were not provided as a matter of routine. However we were told that the OPD does provide Saturday and evening clinics if requested. Private outpatients were able to facilitate occasional evening clinics to meet specific needs.
- X-ray and MRI clinics had been held more flexibly since building work had impacted on the ability of these departments to provide timely services. This had included evening and Saturday clinics. A service manager told us that they were actively seeking funding to increase capacity and offer more regular evening and weekend clinics.
- The radiology department provided 24 hours on-call services.



# Outpatients and diagnostic imaging

## Access to information

- All staff we spoke with said they had access to policies, procedures, NICE guidance and the hospital's intranet. Staff were positive about the trust's intranet and considered that managers communicated effectively with them via e-mail.

## Consent

- We saw that there was a policy and protocols in place for obtaining consent before medical treatment was given. All staff we spoke with were aware of these documents
- Staff we spoke with all understood their role and responsible when obtaining consent to care. We noted that before any treatment or procedure was undertaken staff obtained consent, for example before pain relief was administered the consent of a parent was obtained and the need for this was explained.
- Staff in private outpatients told us that occasionally they had difficulty in obtaining parental consent for treatment because the child or young person was from overseas and not accompanied by their parent or guardian. To manage these situations there was a procedure in place.

## Are outpatient and diagnostic imaging services caring?

Outstanding



Children, young people and their parents received compassionate care and were encouraged to be involved in decisions about their treatment. Feedback was proactively sought to improve the service and staff adopted a can do attitude to meeting children's needs.

Staff were motivated and developed relationships with children and their families that were supportive, identifying and providing emotional support as necessary. Children and families were actively involved in their care and treatment, making informed decisions based on the information and explanations provided by staff.

## Compassionate care

- Throughout our inspection we observed staff providing compassionate and sensitive care that met the needs of children, young people and their parents.

- We saw that all staff demonstrated an ability to speak appropriately to children and young people, ensuring they felt comfortable and their anxiety was reduced. We observed staff proactively approaching children who looked confused or sad, spending time engaging using the interactive digital 3D 'fishing pond' projected onto the floor a point of conversation.
- In private outpatients we observed a child recognising staff and running to them happily and staff responding in a caring manner.
- The parent of a child said, "They've [staff] always been really open and honest with me and the whole family; it's a really good hospital."
- We observed staff preparing a young person who did not speak English for a diagnostic imaging scan. Staff took time and patiently explained the procedure using the mother to translate to reduce the young person's anxiety.
- Radiology staff we spoke with told us that one of their most rewarding challenges was being able to work so closely with young people and reduce their fear around treatments so that they felt good about improving their health. They said that no matter how busy they were, they would always make time to engage with a young person and make sure they felt safe and as relaxed as possible.

## Understanding and involving patients and those close to them

- We observed staff demonstrated a positive, jovial manner and spoke to children and their parents in a friendly manner, engaging them and ensuring they understood their treatment. For example, a volunteer receptionist in the outpatient phlebotomy area was able to engage a very unhappy adolescent in a conversation about their college course by successfully gauging their mood and skilfully building a rapport with them. This had a very positive affect on the young person involved, who was happy to talk about their college course with the volunteer.
- Parents told us they were given time to make decisions and staff made sure they understood the treatment options available to them.
- Some parents we spoke with told us that staff were very good at giving information to them and to their child. One parent said, "The nurses and doctors all discuss all the treatment with my youngster and with me – she is well informed about her treatment and medication."



# Outpatients and diagnostic imaging

## Emotional support

- Play therapists were available in all areas of outpatients to provide support to children who were upset or anxious and to distract them during procedures. This service was particularly promoted in phlebotomy where the play specialist had introduced distraction techniques so that children could have blood taken more easily.
- Staff had a good understanding of the triggers for peoples' emotional behaviour, particularly frustration or aggression. For example, in an outpatients department we noticed that staff were able to identify when parents were becoming distressed over the crowding of the waiting area and they approached people proactively to explain the situation.
- We observed staff were using calming techniques with a mother who became very upset because they could not understand the registration procedure due to a language barrier.
- Staff in diagnostic imaging told us that they received "excellent support" from their managers when providing emotional support to parents and children and that they felt proud that they were so often successful at encouraging young people to be convinced their treatment was for their own good, especially when a procedure could be unpleasant.

## Are outpatient and diagnostic imaging services responsive?

Requires improvement



Outpatients and diagnostic imaging services were planned to meet the needs of children and young people using the service with evidence of flexibility in many areas. Systems were in place to coordinate care with other departments in the trust, these systems were monitored and action taken to improve responsiveness.

Cancellations were minimal and appropriate action taken however; delays in clinics were a routine occurrence. While children and parents were kept informed and action had been taken to address these delays this had not resolved the issue. There was a complaint procedure in place but the number of formal complaints was low. Any informal or formal complaint was listened to and action taken to resolve the issue.

However concerns arose over the reliability of referral to treatment (RTT) data recorded by the trust.

## Service planning and delivery to meet the needs of patients and families

- The outpatients and diagnostic imaging departments had an on going system of monitoring and improving service delivery. To respond to growing capacity, managers and staff had piloted and implemented a number of strategies to meet the demands on the service. For example the MRI clinics had previously begun to open on two evenings a week. The purchase of a new MRI scanner had increased capacity of the service so that the MRI clinics had now been open 5 evenings per week since early 2014. Staff we spoke with said this had been a very positive move.
- Following feedback regarding the temperature in some waiting areas and the impact this was having on some children cooling fans had been installed in waiting areas for staff to use when the areas were very busy.
- To meet increasing demands on services several initiatives had been introduced. These included outpatients departments trialling an 'on-demand' room booking system that was due to run until March 2016 with the aim of maximising the usage of clinical space. The head of nursing had also engaged in research with a major airline to help develop systems to assist the department plan and effectively use their capacity as well as how to manage the increase demand for appointments.
- Diagnostic imaging departments had implemented a system for patients using their services from various other departments and clinics in the hospital. For example rather than having patients attend and wait in a reception area, they were called by staff only when their clinician was ready to see them.
- The head of planning and performance management told us various systems were in place to improve service planning and delivery, which were all patient-focused and aimed to improve patient experience. For example, there were action plans to improve how resources in outpatients were utilised more effectively such as ensuring that each specialty used its resources to maximum capacity.
- There were currently internal consultations taking place to improve the IT infrastructure and support to outpatients and to digitise the patient records system to improve effectiveness.

# Outpatients and diagnostic imaging

- Most teams we spoke with told us that they had daily or weekly huddles to assist them plan short-term service delivery including exploring how problems or unexpected issues would be managed. Staff told us that this practice was useful and helped them to respond appropriately to the daily needs of the service and the patients using it.
- The building works on site had disrupted the MRI department. The service manager told us this disturbance had been minimised by adjusting clinic times to ensure capacity was maintained and patients were seen in a safe and timely manner.
- In diagnostic imaging, staff told us that clinic cancellations were rare and that when they did occur, they spoke with parents by phone the same day to arrange an appointment as quickly as possible.
- The 'did not attend' (DNA) rate for appointments was lower than the England average every month from July 2013 to June 2014. DNA data was tracked monthly and annually to highlight areas that could be influenced and improved by staff.
- Data provided to us showed that 20% of patients waited over 30 minutes after their appointment time to see a clinician in July and August 2014. Many of the parents we spoke with told us that waiting times were often lengthy. One parent said, "When you come here you know it's an all-day job, it's not unusual to be waiting 90 minutes to two hours to be seen." During our observations we saw that staff were proactive in keeping people informed of waiting times. However, we were not made aware of any actions being taken to address this issue.

## Access and flow

- The department had engaged with external research partners to actively improve the flow of patients and management of this experience through their department. This had included staff in main outpatients working with an independent facilitator to produce a process map that described how patients and their families moved through departments. As a result of this year-long project, access and flow had been improved. For example, additional receptionists had been provided in Cheetah outpatients during key times and displays of clinic start times, consultant arrival times and the reasons for any delayed clinics were all displayed prominently in waiting areas.
- Outpatient appointments for private patients were arranged following a referral from an embassy; or referral from hospitals overseas, or a referral by the family. Staff in private outpatients told us that the most frequent issues with flow through the department was when parents arrived with emergency clinical needs because they did not understand the usual A&E system, or because international flights transferring private patients tended to arrive at times when the department was closed. We found a flexible approach to resolving such situations, including liaison and communication strategies with embassies and flexible clinic hours.
- The head of nursing for outpatients told us that a tracking system was used when clinics were cancelled so that the causes could be understood and avoided in future. Where clinically appropriate, patients could sometimes still be seen on their original appointment date even after a clinic had been cancelled. We noted that cancelled clinics had reduced month-on-month from 7% in September 2014 to 4% in December 2014.
- Waiting times between diagnosis and first definitive treatment for all cancers compared were similar to the England average, with 100% of patients waiting less than 31 days from May 2013 to July 2014.
- At the time of our inspection, diagnostic waiting times were similar to the England average based on the number of people waiting at least six weeks.
- Both main and private outpatients had in-house phlebotomy services, which staff told us helped to improve treatment times significantly as children were not waiting for long periods of time in the main phlebotomy services.
- An initial intensive support team review of referral to treatment (RTT) data, which had identified the data as unreliable, also identified inconsistent application of the trust patient access policy. Action was taken to obtain expert resources to lead an improvement programme at service level including the retraining of clinical and non-clinical staff.

## Meeting children and young people's individual needs

- The international outpatients department had engaged with the London School of Oriental and African Studies (SOAS) to provide cultural training for all staff, to help them deliver care and treatment that was culturally

# Outpatients and diagnostic imaging

sensitive. Nursing and medical staff in private outpatients had also completed cultural awareness training, to help them to communicate effectively with patients and parents.

- The head of nursing and the clinical nurse manager in private outpatients told us that when they recruited staff they looked for people who could demonstrate an understanding of the distinct cultural needs that many of their patients had.
- We were told that translation telephone services could be accessed or people whose first language was not English. In the private patient outpatients we noted signage, posters and written information was in English and Arabic, and Arabic translators were available to assist children and families. While these leaflets were not available in other clinics and diagnostic imaging, staff told us they could access translation services promptly.
- The main outpatients department based in another London hospital's building next to the Great Ormond Street Hospital had a number of different areas for children and young people to wait depending on their age. For example there was a separate waiting area for adolescents. The sister in charge told us that this was popular with young people who did not want to wait with young children and that it was effectively managed by giving the patients pagers to let them know when their clinic was ready to see them. We noted this area was age-appropriate and included a games console and was decorated with artwork from previous patients.
- We saw that when parents and families needed private space for emotional reasons, this was provided to them without delay.
- In all waiting and clinical areas we visited information about services and treatments were readily available in print form. In most cases this information was supplied in a format accessible to young people, such as booklets in simple, large print that helped patients to understand a range of topics including local anaesthetics.
- In the main outpatients waiting areas, information files were available that gave parents and their children details of the types of clinics that took place in the department and what facilities were available while they waited to be seen.
- We noted as a result of Friends and Family Test (FFT) survey findings, WiFi access had been improved across the site and was available in most public areas.
- All outpatients' areas displayed information which we noted was updated regularly by staff stating details of the start and waiting times of clinics. Parents told us that although delays in clinics were frequent, they were always kept informed of the length of time they could expect to wait before being seen by the doctor or to be called for their child's test..
- We observed that there was clear signposting that provided information for parents about where to book into specific clinics or departments, such as the waiting area for blood tests or the reception desk to report for an appointment.
- Parents we spoke with told us they had been given a range of relevant information that met their needs in the form of leaflets by staff. They also said they had been directed to relevant websites and encouraged to ask for more information whenever they wanted it.
- Some leaflets were available other languages, for example in private outpatients there were leaflets in Arabic. However, in other outpatient clinics and in diagnostic imaging leaflets were only available in English but staff could access translation services promptly.
- Staff in outpatients told us that they were piloting an adapted FFT to obtain feedback from patients and their families about their involvement in their care. The feedback from these surveys was analysed by the trust's data team and feedback to all outpatient areas. Work had also commenced with the PALS to identify how best to analyse the narrative feedback given from respondents.
- In all waiting areas we visited we found information about how children and parents could provide feedback. We noted that this was in a prominent position and included instructions, forms and a deposit box. The response rate to the survey was currently 30%, which was 6% higher than the initial target set for this new scheme.
- All staff we spoke with were positive about the survey and told us that it had helped them to understand the needs of people in more detail and make positive changes to their service. For example, a paging system in main outpatients had been implemented as a result of feedback from this survey. This meant that children, young people and parents were not restricted to a single waiting area while waiting for their appointment.

# Outpatients and diagnostic imaging

- Parent and staff focus groups had taken place to obtain their views about the parent survey. We were told following these focus groups the response rates had increased
- The pilot was now being rolled out to radiology and the x-ray reception manager told us that their survey display had been installed several weeks ago but that they were still waiting to receive survey cards.
- A modified survey aimed at children and young people was in the process of being piloted and had included a young persons' focus group to test the acceptability of the questions being asked. A project group from local schools had also been formed that had tested whether children and young people would prefer to indicate their feelings about their care and treatment by drawing rather than writing.
- The Friends and Family Test had been launched in private outpatients and had been translated into Arabic to help improve response rates from international patients.
- In diagnostic imaging, a patient satisfaction survey was available at reception desks and a service manager told us that the results were monitored regularly to adapt the service. Changes made as a result of the survey, included more e-mail communication with parents and monitoring noise levels in waiting areas.

## Learning from complaints and concerns

- There was a complaints' policy and procedure in place. This included all complaints being investigated by a senior member of staff and contacting the person making the complaint with five working days.
- We noted that when anonymous complaints were made the complaint's procedure was followed to ensure the concerns were followed up and any improvements in practice implemented.
- Staff we spoke with were able to explain how they dealt with complaints and said information about complaints was provided in the monthly reports which helped them to understand any problems in the service from the point of view of children, young people and their parents.
- Improvements that had been made as a result of complaints included play areas having quiet toys in radiology and wheelchairs being provided in the lobby of the host trust for those attending outpatients.
- Staff told us that most complaints they received were around the frustration people felt at waiting times. To

address this issue display boards in clinical waiting areas had been introduced that stated the planned start time of each clinic, the arrival time of the consultant and how many patients they were scheduled to see.

- Any delays were recorded on the boards so that parents were aware of any delays and the reasons for these. Staff said that this system had proved effective in reducing tension and complaints around delays and that it had also improved consultant reliability and clinic timeliness. However, delays continued to occur and it was not clear if the underlying causes for these delays had been explored.

## Are outpatient and diagnostic imaging services well-led?

Requires improvement



There was a vision and strategy that was used to develop the service and staff are aware of their role in delivering this strategy. The leaders were supportive and strived to deliver and motivate staff. Governance and risk management processes were embedded into practice, fit for purpose and deployed in the best interests of patients and staff.

There was a culture of high quality child centred care, delivered by staff who were proud of their work. Children, young people and their families were engaged in the development of the service and their feedback and views used to improve the standards of care and treatment.

We were concerned at the time required to understand specific details around the numbers of patients affected by problems identified with the trust's RTT data reliability and inconsistent application of the patient access policy, which had been happening for a number of years.

## Vision and strategy for this service

- There was a vision and strategy in place for the department. Staff we spoke with confidently explained what this meant for them and the children and parents using the service.
- There was an annual development of services plan that was used to improve the experience of patients by understanding services from their point of view. Staff we spoke with considered this was having a positive impact on the quality of service provided.

# Outpatients and diagnostic imaging

## Governance, risk management and quality measurement

- There were monthly governance and performance review meetings which covered a range of areas such as operational issues and included front-line staff. This approach assisted senior managers and data analysts understand the delivery of the service from the point of view of those delivering care and treatment.
- Monthly board and risk action group meetings took place which included 30 minutes at the end of the meetings for sharing learning from other divisions. Staff reported that this was effective for engaging staff and idea-sharing across specialties.
- Risk management was embedded in the culture of the service and staff demonstrated that they understood the principles of risk management. We noted this understanding of managing risks had been developed during protected training time and by using monthly audit results such as hand hygiene and checks on the use of WHO checklists in diagnostic imaging to demonstrate how it related to staff and their clinical practices.
- The department risk register included a range of risks with only one risk being on the risk register for longer than six months. This risk related to the lifts in the host hospital building. As this was a structural problem with the lift shafts in a building not owned by the hospital, senior managers told us it was difficult to address. But we found that contingency plans were in place in the event of a lift failure to ensure that clinics would continue to run.
- Audits were used across departments to identify learning and areas for improvement such as audits of cancelled clinics. We found these audits were also used to demonstrate good practice. For example, urology audits were presented at the British Adult and Paediatric Urology Group and at the European Paediatric School for Urology to demonstrate effective clinical practice.
- We were told forums across the services were being set up to obtain the views of staff about how they thought the governance could be improved and what they considered to be the key challenges.
- We were concerned that issues with RTT data and recording had not been picked up sooner. We were

provided with a lack of detailed information in relation to numbers and effects on patients once problems with RTT data reliability and inconsistent application of the patient access policy had been identified.

## Leadership of service

- There were clear lines of accountability and responsibility within the outpatients and diagnostic imaging department. Senior managers took responsibility for their service, for example during our inspection, the administration team in the diagnostic imaging services was short staffed due to the unexpected sickness of five people. We saw the service manager effectively redeployed staff and supported them to deliver a service that was not impacted by sickness.
- Administration staff in diagnostic imaging services said that due to a freeze on recruitment, staff who had left had not been replaced, which meant that there were now three people doing the work of five. We saw that to manage this, staff were deployed more strategically and the service manager had a hands-on approach to supporting his team.
- Staff told us senior managers were approachable, visible and they felt well supported. The majority of managers were reported to be involved in day to day running of the service. A radiographer said, "I've never worked anywhere like this before where the most senior staff are so approachable and friendly. They'll come up to you and ask how your day is going and if you need anything."
- Staff felt managers were transparent and supportive, giving the example of when clinic times had to be changed to accommodate building works, managers involved them and ensured they were not placed under excessive pressure as a result.
- Staff told us that they frequently saw directors and senior managers walking around departments interacting with staff and patients, listening to their views.
- Once issues in relation to RTT data and processes had been identified, a remedial action plan was set up which included recruitment of experts to lead an improvement programme; validating underlying RTT data; clinical review of patients and retraining of clinical and non-clinical staff to improve RTT recording and ensure consistent application of the patient access policy.



# Outpatients and diagnostic imaging

## Culture within the service

- Staff worked in a culture of openness and flexibility, which many staff considered contributed to high levels of satisfaction and pride they felt working at the hospital. Staff were keen to explain that one of the reasons they liked working at the trust was because they were included and liked how they were treated by leadership teams.
- Staff felt valued and that managers checked on their welfare particularly when there had been changes to service. It was also stated that when staff could not attend staff meeting the manager sought out individuals to obtain their views.
- All the staff we spoke with said that they were aware of the 'always' values and that they felt these had been explained thoroughly to them and that they thought it was an important part of developing the service
- The majority of staff we spoke with said there was team working and teams were supportive of each other and always happy to help each other, covering sickness or high workloads.
- Some clinical nurse specialists we spoke with told us that they felt uncertain about their role in the hospital. Some said they felt they were being forced to justify their jobs by keeping extensive records of exactly what they did each day.

## Child, family and staff engagement

- We observed that clinical and non clinical staff were skilled in engaging with children, young people and their families. Engaging them and listening to their views and concerns, taking action as appropriate.
- Children and their families were engaged in the development and delivery of the service through their views being collected using the FFT and the in-house survey in diagnostic imaging.
- We were told forums across the services were being set up to obtain the views of staff about how they thought the governance could be improved and what they considered to be the key challenges.
- Staff were positive about the trust's intranet and the information they had access to. They considered that managers communicated effectively with them via e-mail.

## Innovation, improvement and sustainability

- A proactive approach was taken to identifying and addressing risks and potential issues. Most teams had daily or weekly huddles to assist them plan short-term service delivery including exploring how problems or unexpected issues would be managed.



# Outstanding practice and areas for improvement

## Outstanding practice

- Clinicians from other hospital services delivered specialist training on physical health issues for CAMHS staff. In return CAMHS staff provided training and expertise to other departments across the hospital, for example on learning disability and autism.
- Because the hospital is treating many patients that could be treated at very few hospitals in the UK it is developing ground breaking clinical guidance which it is sharing with clinical colleagues in the wider medical community.
- The hospital has developed a pocket-sized guide to help staff working with children with learning disabilities.
- The Feeding and Eating Disorders Service (FEDS) received 100 % approval in the latest Friends and Family test with 93% saying they were extremely likely and 7% saying they were likely to recommend the service.
- The Psychological Medicine team provided an outreach service across the country where necessary.
- Staff in CAMHS were actively involved in research in their specialist areas including Autism and Feeding and Eating disorders.
- CAMHS introduced a screening tool for mental health problems and the psychological medicine team conducted a study to improve the understanding of the patient experience, diagnosis, treatment and outcomes regarding non-epileptic seizures in children.
- The FEDS team developed a policy around re-feeding syndrome to increase understanding of the issue.
- In critical care there were excellent mortality and morbidity meetings, and robust safety monitoring of all patients.
- The Intensive Care Outreach Network (ICON) and Clinical Site Practitioners (CSP) are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours a day, seven days per week.
- In pharmacy services the chief executive receives monthly reports of prescribing errors; a daily check ensures all electronic prescriptions are screened before the end of each weekday (Monday to Friday) and patients are informed by text message when prescriptions are ready.
- Intransitional care young people feel empowered by the Young Persons' Forum.
- Joint transitional care clinics are held with on-going hospital providers.
- In outpatients weekly education sessions were protected to ensure staff maintained currency in mandatory areas and had the opportunity to take part in further specialist training from a clinical educator

## Areas for improvement

### Action the hospital MUST take to improve

Importantly the hospital must:

- Resume WHO checklist audits in surgery
- Ensure that there are clear arrangements for reporting transitional care service performance to the board.
- Ensure that its referral to treatment (RTT) data and processes are robust and ensure that staff comply with the trust's patient access policy in all cases.
- Ensure greater uptake of mandatory training relevant to each division to reach the trust's own target of 95% of staff completing their mandatory training.

- Ensure that, particularly in critical care, communication between senior nurses and senior medical staff is enhanced and that the contribution of nursing is fully reflected in the hospital's vision.

### Action the hospital SHOULD take to improve

In addition the hospital should:

- Ensure early improvements in the environments of wards which have not been refurbished, rebuilt or relocated.

# Outstanding practice and areas for improvement

- Standardise radiation protection training for junior radiologists to overcome inconsistencies caused by short rotations.
- Develop a dedicated advocacy service for its Child and Adolescent Mental Health service ( CAMHS).

## 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

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider was not complying with Regulation 17 2 (a) (c) and (f). Systems were not sufficiently established or operated effectively to ensure the provider was able to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk, which arise from carrying on of the regulated activity because:

- 1) Irregularities were discovered in the trust's management and recording of referral to treatment practice and data over several years meaning that the data was unreliable. This affected mainly but not uniquely the surgical and outpatient and diagnostic divisions.
- 2) The trust and also local divisions had not managed referral to treatment efficiently and the inefficiencies had not formally been picked up and managed and remedied at both local division and trust level.
- 3) At the same time the trust had not managed access to treatment for all patients in a consistent way in accordance with its own access to treatment policy.