The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital

Quality Report

The Royal Orthopaedic Hospital, Bristol Road
Birmingham. B31 2AP
Tel: 0121 685 4000
Website: www.roh.nhs.uk

Date of inspection visit: 20/07/2016
Date of publication: 04/01/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this unannounced inspection on 20th July 2016 which was a focused inspection of the high dependency unit (HDU) specifically looking at paediatric care.

We last inspected The Royal Orthopaedic Hospital in July 2015 when we conducted a focused follow up inspection of HDU (as part of the critical care core service) and the outpatients department (OPD). This was because we identified concerns in 2014 with one of the five questions in each area rated as inadequate.

Following the focused inspection in July 2015, we saw improvements in HDU however; we rated the service as requires improvement. The ratings remained the same for HDU as in 2014; however, the issues identified were different and had an impact across the five domains.

There were significant concerns specifically the care of children at the trust including paediatric nursing and medical cover and the HDU environment. We therefore told the trust they must take action to improve both of these areas of concern. Other areas of concern that the trust were required to act upon included contribution of data to Intensive Care National Audit and Research Centre (ICNARC) or similar, to benchmark the service against other similar hospitals, to address the HDU toilet facilities so that they are single sex and can accommodate children and multi-disciplinary ward rounds and handovers should take place.

In view of the paediatric care concerns identified, during a meeting with a Deputy Chief Inspector, it was agreed that the trust commission a review by the Royal College of Paediatrics and Child Health (RCPCH) of their paediatric service. The trust accepted this and the review took place in March 2016 with the report following in June 2016.

The report described many recommendations with some serious concerns relating to non-compliance with national professional guidance. Of greatest concern were the continued absence of paediatrician support and the governance processes relating to activity involving children and young people.

Since the publication of the 2015 report, the trust has put a comprehensive action plan in place to address the issues identified. This action plan is ongoing with several actions outstanding.

The reason for this focused inspection was following receipt of the RCPCH report and action plan from the trust on 21st June 2016, which raised some concerns with us. Our concerns related to the action plan, to address all the areas of improvement required which were extensive. We decided we needed to visit on-site to better understand how the trust was going to address the recommendations and make timely improvements.

In view of the focused inspection with the aim to gain assurance of paediatric care in HDU only, we did not rate this service.

We spoke with 22 staff in total including nursing and medical staff, local and senior management. We visited HDU and the governance department but also spoke to nursing staff who worked on the children's ward (ward 11).

Our key findings were as follows:

- The trust had made improvements with paediatric nursing cover with plans to increase provision in line with national guidance.
- Medical cover remained a concern as identified both CQC and the RCPCH; however, the escalation process for the deteriorating child had been strengthened.
- We found a printing error on the Paediatric Early Warning Score (PEWS) chart.Regular staff did not follow the printed advice so children were not at risk. However new or temporary staff may have used the form as printed and this could put children at risk.

Summary of findings

- The trust did not have a fully realised children's strategy to achieve the vision or a senior leader with paediatric experience. Plans were in place to address these.
- The main door into HDU was broken and had been an issue for some time. This was both a security risk and at times prevented staff from entering with their security passes.
- Governance processes around care of the child require improvement in particular, incident reporting and exposure at quality and safety meetings.
- We observed poor hand hygiene on HDU, with clinical staff entering the unit failing to wash their hands or use hand gel.
- The manager of HDU was new to post within the two weeks prior to our inspection.
- Staff were welcoming of the changes to paediatric care and felt improvements were necessary.
- Some improvements we saw since the July 2015 inspection related to medicines safety, and environmental plans for HDU.

The trust should:

- Act upon the recommendations of the RCPCH to develop and implement policies in a timely manner.
- Implement a fit for purpose PEWS chart immediately to detect the deteriorating child.

Please note the requirement notices served in the report published December 2015 still apply and the trust is still working on the action plan associated with them.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Critical care	Requires improvement 	Overall, we found some improvements in the safety of paediatric care provision and within the leadership of this service since our last inspection in 2015. The trust was preparing to build a new purpose-built HDU ward, staff reported incidents and received feedback, medicines were stored appropriately, and the wards we visited were visibly clean. However, staff did not always follow hand hygiene procedures and resuscitation trolleys were not checked daily as per trust policy. Although we noted some improvements, there continued to be a lack of strategy, policies and procedures and robust governance processes for the care of children. The trust developed an extensive action plan following the RCPCH review, which linked with the trust's existing HDU action plan following our 2015 inspection. We raised concerns about the pace of the completion of some actions. Staff we spoke with welcomed the improvements required for paediatric care and senior management thought the trust was in a state of cultural change, one open to scrutiny and challenge. The trust demonstrated that they were engaging with staff, the public, external stakeholders, and the local children's acute healthcare provider to improve the care of children at the trust. Significant improvements were required for the care of children with spinal deformities relating to the number on the waiting list. The resolution of this was complex and required the input and co-operation of several stakeholders. HDU changes within the inspection action plan had been dependent upon people resource, financial and commissioning constraints and required detailed discussion and planning, including external stakeholders. Compliance with the duty of candour regulation had significantly improved with the development of a tracking tool and we saw evidence of its effectiveness.

The Royal Orthopaedic Hospital

Detailed findings

Services we looked at
Critical care

Detailed findings

Contents

Background to The Royal Orthopaedic Hospital

The hospital was established in 1817 and became a foundation trust in 2007, which means the trust has more freedom in how they run their hospital and in meeting the demands of them. The hospital is situated in the south of Birmingham.

The hospital is a tertiary specialist orthopaedic centre treating the local population and people from across the UK and internationally.

The trust specialises in planned treatments of joint replacement, spinal and hand surgery as well as paediatrics. It is nationally recognised as a centre of excellence for the treatment of bone tumours and for having a specialist bone infection unit.

The trust works closely with the local children's hospital in particularly to care for children with spinal deformities.

This was an unannounced focused inspection of paediatric care within the high dependency unit (HDU) and this was because of concerns raised by the RCPCH review. This inspection was required to gain assurance that the trust was taking timely action in view of our inspection in 2015 and the RCPCH findings.

Our inspection team

Our inspection team was led by:

Inspection manager: Donna Sammons.

The team included two CQC inspectors and one assistant inspector.

How we carried out this inspection

Prior to the inspection, we analysed the RCPCH report and the initial action plan provided by the trust alongside the on-going trust action plan following our concerns found during the 2015-focused inspection.

The inspection was unannounced and was delivered in one day. During the inspection, we looked at documents; spoke with staff including some of the executive management team and observed HDU and clinical practice. In addition to this, we reviewed information we held and information in the public domain.

We did not inspect to rate this service. The aim of this inspection was to gain assurance that paediatric care within HDU was safe and well led.

Detailed findings

Facts and data about The Royal Orthopaedic Hospital

The Royal Orthopaedic Hospital NHS Foundation Trust is a small, specialist teaching hospital offering planned orthopaedic surgery with 135 beds. The trust provides services to the city of Birmingham with a population of 1,073,045 but is also a tertiary referral centre.

Critical care

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

Information about the service

The HDU at The Royal Orthopaedic Hospital has 12 beds, including four side rooms. The unit was commissioned to provide up to 10 level two beds (level two beds are for patients who have high dependency needs but are not ventilated). The HDU provided care and treatment for both adults and children. Generally, children were cared for by staff in two side rooms. Adults received care in the main unit and the two other side rooms when needed. We did not inspect the care provided to adults on HDU on this inspection. No children were on the unit on the day of our inspection but we spoke with staff both on HDU and paediatric nurses on ward 11, the children's ward.

The trust is a member of the regional critical care network. The unit has been submitting data to the Intensive Care National Audit and Research Centre (ICNARC) since April 2016.

Following the focussed inspection in July 2015, there had been an on-going HDU action plan to make improvements. Actions include improved paediatric HDU facilities, ensuring appropriately trained paediatric nurses were available for the care of children, collection and submission of children's safety thermometer data and improved policies relating to paediatric care.

The trust developed an additional action plan following the RCPCH report recommendations, with a few actions overlapping from the previous action plan for HDU improvements.

During the period of July 2015- July 2016, there had been 126 children and young people (up to the age of 18) admitted to HDU. The small number of children cared for at the trust as a whole means that the safe provision of paediatric care is complex and requires modifications of the recommendations for a specialist non-children's hospital.

Critical care

Summary of findings

Overall, we found some improvements in the safety of paediatric care provision and within the leadership of this service since our last inspection in 2015. The trust was preparing to build a new purpose-built HDU ward, staff reported incidents and received feedback, medicines were stored appropriately, and the wards we visited were visibly clean. However, staff did not always follow hand hygiene procedures and resuscitation trolleys were not always checked daily as per trust policy.

Although we noted some improvements, there continued to be a lack of strategy, policies and procedures and robust governance processes for the care of children. The trust developed an extensive action plan following the RCPCH review, which linked with the trust's existing HDU action plan following our 2015 inspection. We raised concerns about the pace of the completion of some actions.

Staff we spoke with welcomed the improvements required for paediatric care and senior management thought the trust was in a state of cultural change, one open to scrutiny and challenge.

The trust demonstrated that they were engaging with staff, the public, external stakeholders, and the local children's acute healthcare provider to improve the care of children at the trust. Significant improvements were required for the care of children with spinal deformities relating to the number on the waiting list. The resolution of this was complex and required the input and co-operation of several stakeholders.

HDU changes within the inspection action plan had been dependent upon people resource, financial and commissioning constraints and required detailed discussion and planning, including external stakeholders.

Compliance with the duty of candour regulation had significantly improved with the development of a tracking tool and we saw evidence of its effectiveness.

Are critical care services safe?

- The trust had implemented action plans since our last inspection to ensure that children received appropriate care by paediatric nurses and doctors in order to guarantee patient safety. However, these actions were in the initial stage of implementation at the time of our current visit.
- The availability of one toilet within HDU meant that both males and females (adults and children) used the same facilities, which was not acceptable. During the current inspection, we saw the trust's plans to address these issues with a new purpose-built HDU ward.
- There were appropriate systems in place to highlight risks, incidents and near misses. Management put in place appropriate actions to ensure staff learned lessons.
- The HDU was visibly clean and there were appropriate systems in place to minimise the risk of cross-infection. However, we saw that staff were not always following hand hygiene procedures.
- The availability and use of equipment was found to be suitable to meet patients' needs. We did note that daily checking of the resuscitation trolley did not always take place, in line with the trust's policy.

There were suitable arrangements for the safe administration and storage of medicines.

Incidents

- In July 2015, we found it was not possible to identify whether incidents in the trust involved children or adults. This meant there was no means of identifying trends in incidents involving children and ultimately no wider learning from these.
- At the time of the current inspection, staff could not identify whether the incident involved a child. The electronic form was about to be updated to allow for the identification of incidents relating to children. This would then enable the trust to identify trends specifically involving children.
- A senior manager told us that there was still a lack of reporting culture on HDU for paediatric specific staffing incidents. This was because prior to our inspection July 2015, adult nurses cared for children and thought this

was an acceptable staffing solution. The manager told us that once there are two paediatric-trained nurses on HDU 24 hours a day, they will have a high expectation for staffing incident reporting culture to improve.

- There was one never event involving a child. (Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.) This was concerning wrong site surgery. The trust had commenced an investigation into the incident and concluded that it did not trigger duty of candour. However, the trust decided to follow the process. The investigation was ongoing at the time of our visit. Documents provided by the trust since the inspection demonstrated the completion of the investigation, which was shared with commissioners. It also demonstrated that duty of candour regulations did apply. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers. At this time, all NHS trusts needed to ensure compliance against this regulation.
- Duty of candour regulations came into place for all NHS trusts in November 2014. In December 2015, we notified the trust to improve its compliance processes to comply with this part of the regulation. Following publication of our inspection report in December 2015, the trust produced a detailed action plan to respond to the recommendations detailed within it. We saw that a process was in place to help identify and meet the parts of the regulation.
- We saw evidence that the annual mandatory training programme had been adapted to include Duty of Candour training. This was to ensure all staff would comply with this regulation.
- All staff received duty of candour awareness as part of the annual mandatory training programme.

Safety thermometer

- We saw evidence of staff using a paediatric and young person's safety thermometer within critical care. The NHS Safety Thermometer provides a ' that can be used alongside other measures of harm to record the proportion of patients receiving 'harm free' care.
- The safety thermometer data we reviewed included data on
- However, management carried out the safety thermometer audit on Wednesdays. Safety thermometer is a national audit and is undertaken across all providers on a given Wednesday of the month to give a national comparison. The Trust therefore does not have the ability to alter its day of collection. The unit was more likely to have children on the unit on a Friday or Monday. Therefore this tool was not giving assurance that children received harm free care and the Trust should consider other measures to give assurance of harm free care.

Cleanliness, infection control and hygiene

- HDU was visibly clean and well maintained.
- The HDU target for staff following the correct hand hygiene procedure was 90%. In the three months from April to June 2016, an audit showed staff achieved between 70% and 100%. Management had implemented an infection prevention quality improvement tool to improve compliance with hand hygiene.
- We observed clinical staff of all levels not using hand gel or washing their hands when entering the HDU.We also noted one senior member of staff did not follow the uniform policy.
- We saw documents that demonstrated that infection control issues identified in HDU were discussed at senior management level and actions identified were undertaken. We saw evidence in the team meeting minutes (19 July 2016) that the ward sister confirmed she would add hand hygiene audits to the coordinator's check list. This would still be the responsibility of all staff to complete, however the coordinator would ensure this was completed before patient discharge. The sister also reminded staff there was a legal requirement to complete the audits and the trust would be fined if this was not done.
- The week starting 26 July 2016 showed 100% compliance evidencing that the above interventions were successful in achieving compliance with the hand hygiene procedure.
- We saw that hand sanitising gel was readily available.
- Prominent reminders to use hand gel and follow the hand hygiene procedure were evident.

Critical care

Environment and equipment

- In December 2015, we highlighted concerns around there being only one toilet for use by both adult male and females plus paediatric patients. The trust informed us that separate toilet facilities would be available by August 2016.
- In line with our previous findings, the Royal College of Paediatric and Children's Health (RCPCH) found the two-paediatric rooms adjoined to the adult HDU were small, with little circulation and space around beds and equipment.
- During this inspection, we saw the trust's plans to address these issues with a new purpose-built HDU ward. The plans included a new entrance and en-suite bathrooms. These would improve the environment and conditions for paediatric patients and carers. An intercom would be fitted for staff within the paediatric area to contact colleagues working on the adult unit, should they require further assistance.
- The architect's plans for the new build were available for staff, patients and visitors to see. A feedback form had been designed for patients, parents and carers to complete regarding their thoughts and ideas for the new building. These forms had only just been introduced to the ward therefore we only saw two completed forms.
- Visitors used a buzzer system to gain access to the HDU via the main door. This ensured the security of the unit. However, when we arrived we found we were able to enter the unit as the door was unlocked. Staff told us this was an ongoing problem, which they had reported numerous times. We raised this issue with the senior management team at the end of our inspection, and they assured us the trust would fix it the next day.
- We highlighted concerns in the 2015 report around access to paediatric patients in an emergency. This was due to carer beds in the paediatric side rooms of HDU.
- We saw that management had removed beds and replaced them with recliners for parents' use.
- Resuscitation trolleys were to be checked and signed as being 'in order' on a daily basis, as per trust policy. However, we found missing signatures for three days in February 2016, one day in April 2016 and three days in June 2016. We confirmed this with the ward management who said they had not been completed which was against daily check protocol.

Medicines

- In 2015, we found that access to the intravenous (IV) fluids was not secure and therefore there was a potential risk to safety.
- At the time of this inspection, we saw evidence that IV fluids were stored appropriately and securely in line with patient safety guidelines.

Records

- On ward 11 (the children's ward), we saw each child had an identified lead clinician; this name was easily identifiable in the clinical notes.
- However, staff did not clearly identify the lead clinician in HDU care charts at the foot of the patient's bed. For example, the named nurse was often a signature, which was illegible. Instead of a named consultant, the team the patient was under (for example, oncology) was often recorded. The Academy of Royal Medical Colleges guidance (Taking Responsibility: Accountable Clinicians and Informed Patients, June 2014) states that patients should have a named clinician with the overall responsibility for their care and a named nurse who is directly available to provide information about their care. The Secretary of State for Health in England has supported the concept for having an accountable consultant and nurse with their name over the bed.
- The trust's polices were available and accessible to all staff on the intranet.
- We observed a lack of knowledge amongst staff with regard to accessing information electronically on HDU relating to past children and young persons' admission figures. When we requested admissions figures, staff directed us to this data via a paper diary. Senior management confirmed that that information was collected by the trust.

Safeguarding

- The Royal College of Paediatric and Child Health (RCPCH) advised that the Royal Orthopaedic Hospital (ROH) needed to review and update the children's safeguarding policy in line with current professional guidance. (Safeguarding children and young people: roles and competencies for healthcare staff, Intercollegiate Document: Third Edition March 2014). care
- On 5 July 2016, the trust updated the action plan to reflect that it had a policy approved by clinical commissioning group safeguarding leads. Senior

managers were also updating references within the policy to reflect the latest guidance document. This policy was easily accessible for all staff on the trust's intranet.Staff we spoke to were aware of who the safeguarding lead was.

- During the previous inspection we found that HDU staff had had been trained safeguarding children level 1, 2 and 3.

Assessing and responding to patient risk

- We saw the HDU was using a PEWS (Paediatric Early Warning Scores) assessment system. The system enabled staff to see if a patient's condition was deteriorating and escalate appropriately.
- We looked at the guidance for staff on using the system and found an error in details of what the scoring system meant. We highlighted this discrepancy to a staff member. They confirmed this was incorrect and told us it must have been a printing error. We found that staff used the form correctly despite the incorrect advice contained. The risk was if staff who were unfamiliar to the hospital used the form as printed.
- Staff we spoke with told us they would contact an anaesthetist if they observed a PEWS score of three or more. However, this was not reflected in the guidance on the PEWS chart as this directed staff to fast bleep the doctor in the first instance and then to contact the outreach team (in hours of cover) and bleep holder (out of hours).
- We have since seen confirmation in writing from senior management that the hospital will be adopting the national PEWS scoring system. A new PEWS Policy will also be adapted to include sepsis triggers. Sepsis, also referred to as blood poisoning or septicaemia, is a potentially life-threatening condition triggered by an infection or injury. A working group had been established including anaesthetic and nursing staff. The trust were also developing a deteriorating paediatric patient policy.

- The ward staff reviewed the theatre lists in advance. If they found paediatric patients were not on top of this list to have their operation they discussed possible changes with the consultant and anaesthetist. This was in line with the standard operating procedure recently produced by the hospital.
- The RCPCH reported that escalation and resuscitation policies for care of the deteriorating child were urgently required including children with complex oncology co-morbidities, which reflect current guidance. Children receiving chemotherapy were also at risk of deterioration. This meant they needed the additional support of the HDU. We saw evidence in the form of HDU team meeting minutes that the matron was developing a deteriorating paediatric patient policy.

Nurse staffing

- RCN standards for clinical professionals and service managers (2013) identify that there should be a minimum of two registered children's nurses on duty at all times in all inpatient and day care areas for children and young people's services. This meant when one child was on HDU there needed to be two paediatric-trained nurses on the unit. The HDU had not met this standard at the time of the inspection in 2015.
- Management reviewed paediatric nurse cover on a shift-by-shift basis. Every shift had paediatric nurse cover from June 2016, even where no children were present on HDU. This was to ensure that there was an appropriate nurse available to care for a child should there be a paediatric emergency admission to HDU.
- The ROH planned to have three registered children's nurses on ward 11 on each shift as a safety measure.
- The ROH had implemented a 'critical care passport' scheme as part of its action plan. This is a competency framework to achieve critical care skills for children's nurses working in level one and level two paediatric critical care units.
- ROH implemented a rotational programme between ward 11 and HDU in order to address the CQC findings and to ensure a registered children's nurse cared for all children in HDU at all times.
- Management allocated ward 11 staff eight weeks to work on the HDU in order to achieve these competencies.
- Most of the staff told us that due to the low number of children passing through the HDU they had limited opportunity to achieve these competencies. Staff also told us that certain competencies were not relevant to ROH; for example, they did not perform tracheotomies (an incision in the windpipe made to relieve an obstruction to breathing).
- Staff used a paediatric-mapping tool to ensure the correct level of staffing for each shift.

Critical care

- When shifts could not be fully staffed from their own staff working their contracted hours, we saw evidence that shifts were filled by bank staff (the hospital's own staff working additional hours) or agency staff.

Medical staffing

- In our 2015 report, we highlighted that medical paediatric cover was not sufficiently robust. The arrangement at the time of the inspection involved a paediatrician visiting the hospital twice a week, but this did not include HDU unless specifically requested by staff. Twenty-four hour, seven days a week telephone support was also offered as a service level agreement with a local specialist paediatric provider.
- The current arrangements were not adequate to meet the needs of children within the HDU in the event of a deteriorating child or young person.
- The RCPCH and CQC inspectors were concerned about the continued absence of senior paediatric advice and governance. In particular, it highlighted the arrangement with the local specialist paediatric provider for provision of part time presence of paediatricians and on call telephone advice.
- The trust executive were exploring an arrangement with a local specialist children service, where paediatricians would be on site Monday to Friday in core service hours. This would enable them to support staff if a child deteriorated along with other ROH medical staff. Out of hours arrangements were in place to support ROH staff in the event of an emergency involving a child.
- Within the RCPCH action plan, part of the mitigation was to ensure the paediatricians routinely visited HDU twice a week. We were unable to ascertain whether the hospital had implemented this due to the lack of paediatric patients on the ward since the action point was triggered. Executive management told us they thought this practice was in place at the time of the inspection.

The trust was planning to set up daily paediatric clinics. Paediatric consultants from the local specialist paediatric provider would be running these. The consultants would visit all paediatric patients admitted to ROH as part of their visit. This would ensure robust paediatric medical cover at ROH.

Are critical care services effective?

Are critical care services caring?

Are critical care services responsive?

Are critical care services well-led?

- Since our inspection in 2015, there have been considerable changes and some improvements to the paediatric provision within HDU and across the trust, additionally with some changes to leadership.
- The RCPCH review confirmed and raised several concerns that we identified in July 2015 and therefore concerns exist that action was not timely. The review found that the trust were non-compliant with areas of established national professional guidance for the care of children undergoing surgical procedures.
- We found staff to be positive about the changes that have been made in paediatric care and welcoming of further improvements. Staff wanted to be involved in the development of the service.
- The trust continued to lack a clear strategy, policies and procedures for children although recruitment for a senior leader for paediatric care had been appointed around the time of the inspection to lead this work.
- Governance processes for children's care were insufficient including a lack of incident reporting culture, quality measurement and presence within governance meetings. Access and flow to HDU was not robustly monitored.
- The trust actively engaged with key stakeholders to discuss the RCPCH recommendations and the future of paediatric care at the hospital. There was evidence of staff and public engagement but there were plans to increase this.
- The trust had designed a duty of candour 'tracker' process to improve their compliance with the duty of candour regulation and this was proving to be successful.
- The trust was in conversations with the local children's hospital and commissioners to improve spinal surgery wait times for children, which were up to, and over 52 weeks.

Critical care

- Since our inspection in 2015, there have been considerable changes and some improvements to the paediatric provision within HDU and across the trust, additionally with some changes to leadership.
- The RCPCH review confirmed and raised several concerns that we identified in July 2015 and therefore concerns exist that action was not timely. The review found that the trust were non-compliant with areas of established national professional guidance for the care of children undergoing surgical procedures.
- We found staff to be positive about the changes that have been made in paediatric care and welcoming of further improvements. Staff wanted to be involved in the development of the service.
- The trust continued to lack a clear strategy, policies and procedures for children although recruitment for a senior leader for paediatric care had been appointed around the time of the inspection to lead this work.
- Governance processes for children's care were insufficient including a lack of incident reporting culture, quality measurement and presence within governance meetings. Access and flow to HDU was not robustly monitored.
- The trust actively engaged with key stakeholders to discuss the RCPCH recommendations and the future of paediatric care at the hospital. There was evidence of staff and public engagement but there were plans to increase this.
- The trust had designed a duty of candour 'tracker' process to improve their compliance with the duty of candour regulation and this was proving to be successful.
- The trust was in conversations with the local children's hospital and commissioners to improve spinal surgery wait times for children, which were up to, and over 52 weeks.

Vision and strategy for this service

- Since our July 2015 inspection, there has been an improvement in the recognition and focus for a designated vision and strategy for children's care at the hospital.
- HDU changes within the inspection action plan had been dependent upon people resource, financial and commissioning constraints and required detailed discussion and planning, including external stakeholders.
- The paediatric care vision and strategy was in development with the first children's board meeting scheduled for 25th July 2016.
- HDU staff were aware of the RCPCH review and the improvements that were required in paediatric care at the trust. Staff welcomed the review and were positive about the improvements required.

Governance, risk management and quality measurement

- From the RCPCH report, one of the immediate actions recommended was that the report was shared at board level and an action plan developed. We saw evidence of the private board meeting minutes (June 2016) where the report was shared and recommendations discussed.
- The trust did not discuss children and young people's care within their monthly governance meetings but there were plans to do so and have a designated section included in the quality report for the sight of the board.
- The trust had scheduled the first children's board meeting for 25th July 2016. We saw the terms of reference for this board. The purpose of this board was to monitor quality and safety of the care provided to children and young people by the trust, in line with national guidance.
- At the time of our inspection, children's clinical incidents were not reviewed separate to those of adults. The RCPCH review highlighted this as a concern.
- The incident reporting system did not have an option to categorise that an incident involved a child. This was because the system did not have a function to do so. When we raised this with senior managers, they said they would contact the company to get this function added to the form. Incidents relating to children were raised but they could not be easily identified for overall reporting, and only if the date of birth of the child was added. We also found that staff recognised that incidents relating to appropriate levels of suitably qualified staff on the unit would increase, with staff awareness. Following our inspection, the governance team acted upon this and put this function in place.
- Since our inspection in July 2015, the executive team had improved the nursing cover of paediatric-trained nurses on HDU. There had been recruitment issues because of the lack of interest in the post. The trust mitigated the risk by ensuring all adult trained nurses on HDU have paediatric competencies. This meant that

shifts that could not be covered with paediatric nurses; there were competent staff to care for children. From September 2016, there will be two paediatric nurses on duty 24 hours a day.
- One area where the trust felt they were unable to meet the recommendations and guidelines, related to paediatric medical cover. The trust presented an alternative solution, which was broadly accepted at a stakeholder meeting. Part of this involved paediatric clinics taking place at the trust that meant paediatricians would be on site in core hours and could undertake ward rounds of all paediatric inpatients.
- The HDU local risk register included the risk of paediatric nursing cover shortfalls. All risk register items had a risk owner and an operational lead with a review date. This risk register item met the criteria for the board assurance framework, meaning the level of risk was reviewed at board level.
- The local risk register included that the current HDU environment cared for both adult and paediatric patients on the same unit. Children were separated as much as possible in the side rooms. This issue will be addressed once the new purpose built HDU facility is completed in January 2017, for which board sign off had been sought.
- HDU staff monitored daily paediatric admissions to the unit manually using paper records but did not to gain an overview of access and flow. We asked how they would monitor the monthly and annual admissions to the unit but this data was not routinely monitored. The trust provided this data following our inspection. This meant that HDU staff were not reviewing paediatric access and flow to the unit.
- ICNARC data collection began in April 2016 and data had been submitted since July 2016. This was a trust action because of the CQC July 2015 inspection

Leadership of service

- The HDU band 7 manager had started in post two weeks prior to our inspection. The matron for HDU had been in post since January 2015.
- The trust did not previously have a children's lead with a paediatric nurse qualification. On the day of our inspection, the trust told us they had appointed a band 8a matron for the role and expected them to start from November 2016. This post would be important for shaping the future of paediatric care at the trust.
- The RCPCH report was presented to the trust board in June 2016. Two board members said that there had been some challenge to whether the trust should continue to provide paediatric care in view of the review findings.
- The nursing leadership were visible on the unit on a daily basis.
- Leadership at all levels were responsive to ensuring improvements were made.
- The trust had immediately acted upon the RCPCH concern that there was not an executive level champion for children's care at the trust with the Director of Nursing and Governance taking this role.

Culture within the service

- Staff we spoke with were proud to work for this specialist hospital and felt the improvements in progress for paediatric care was positive.
- Since our inspection in July 2015, the trust had significantly improved processes and understanding for the duty of candour regulation. We viewed three incidents, which triggered duty of candour and found the trust to be compliant. They had a duty of candour 'tracker', which was a system, which ensured all cases were identified and tracked against each of the regulation requirements.
- Two senior managers said that the hospital was undergoing a cultural change from a traditional hierarchical consultant led one to one of modernisation and more open to challenge.

Public engagement

- Architect plans had been developed, and the gaining of public opinions was in the early stages. They were on display and staff understood they were to share feedback with senior management.
- We saw patient feedback forms on HDU for patients and relatives to fill out about the plans for the new HDU facility. Two forms had been filled out and staff told us this was due to the small numbers of paediatric patients being admitted to the unit.

Staff engagement

- Senior management told us that they shared the RCPCH report findings with medical staff in an open invitation meeting.

- Some staff told us that they were not involved in the development of the new HDU plans and that feedback from senior management was poor.
- The trust held a stakeholder meeting on 26th July 2016 after our inspection to engage with internal and external stakeholders in the decision for moving forward with improved paediatric provision at the trust. The outcome of this meeting was to begin the new HDU build and to re-design and negotiate the medical and nursing paediatric service level agreements with the local children's hospital.

Innovation, improvement and sustainability

- The trust was keen to adopt a joint associate medical director role to work across both ROH and the local children's hospital to improve children's orthopaedic surgery at both sites. Both trusts' agreed it would be beneficial moving forward with children's orthopaedic care and the advertisement for the post to go ahead.
- At the stakeholder event held by the trust, they highlighted their concerns at the on-going issue of prolonged wait lists for children's spinal deformity surgery. All stakeholders recognised that this issue was complex and a team approach from all stakeholders was required to improve this wait list at both ROH and the local specialist children's provider.
- The duty of candour 'tracker' that the trust developed was innovative to ensure that they meet every requirement of the regulation, whilst it was still dependent on staff recognising the triggers to begin the process.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

Please note the requirement notices served in the report published December 2015 still apply and the trust is still working on the action plan associated with them.

- Act upon the recommendations of the RCPCH to develop and implement policies in a timely manner.
- Implement a fit for purpose PEWS chart immediately to detect the deteriorating child.