

NEXT PHASE METHODOLOGY (2017)

Operating Model area: Specialist Trusts

Sector: Acute

Product title:

Inspection framework: NHS acute hospitals (specialist children's hospital)

Core service: Neonatal services

Neonatal services are provided for new born babies who need extra care, for example, because they are born prematurely or need treatment in hospital after birth. They are provided in a variety of settings depending on the treatment required, including neonatal intensive care units (NICU) and special care baby units (SCBU).

It does not include care provided in the emergency department, as this is covered under the urgent and emergency core service.

Areas to inspect*

The inspection team should carry out an initial visual inspection of each area. Your observations should be considered alongside data/surveillance to identify areas of risk or concern for further inspection.

- Neonatal Intensive Care Unit (NICU)
- Local Neonatal Unit (LNU)
- Special Care Unit (SCU)
- Any areas providing Level 1, 2 or 3 care (see below)
- Neonatal transport service
- Obstetric theatres (for emergency Caesarean section) (If on premises)
- Delivery suite (If on premises)
- Labour ward (If on premises)
- Post-natal ward (If on premises)

Interviews/observations

You should conduct interviews of the following people at every inspection, where possible:

- Relatives and those close to people who use the service (taking particular account of individual circumstances at the time of inspection).
- Clinical director/lead
- Nursing lead for each ward/unit/area
- Directorate/divisional manager
 - Manager responsible for the neonatal transport service
 - Obstetricians (if on premises)
 - Midwives (If on premises)

You could gather information about the service from the following people, depending on the staffing structure:

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| <ul style="list-style-type: none"> • Surgeons and physicians not working within neonatal services but who interact with the service • Neonatal care medical and nursing staff and multidisciplinary team members such as pharmacist, anaesthetic lead, radiology lead • Trainee doctors • Bereavement officer / counsellor • PALS representative • Ambulance / neonatal transport service crews of all grades | <ul style="list-style-type: none"> • Representative(s) from safeguarding team and paediatric liaison • Children's community nurses and liaison health visitors (even if employed by another trust) • AHP staff • Matrons, Nurses & Healthcare Support Workers • Doctors • Support staff e.g. Ward managers, porters, receptionists, admin etc. |
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Links to useful documents/ further reading:

[Neonatal Tool Kit](#)

British Association of Perinatal Medicine (BAPM), [Standards for Hospitals providing Neonatal and High Dependency Care](#)

Definitions of neonatal units	
Level	Definition
1	Units provide Special Care but do not aim to provide any continuing High Dependency or Intensive Care. This term includes units with or without resident medical staff.
2	Units provide High Dependency Care and some short-term Intensive Care as agreed within the network.
3	Units provide the whole range of medical neonatal care but not necessarily all specialist services such as neonatal surgery.

Service-specific things to consider

We have identified a number of specific prompts for this specialist service that are set out below. Inspection teams should use these **together with** the standard key lines of enquiry and prompts. These are not intended to be a definitive list or to be used as a checklist by inspectors.

*Indicates information included in the inspection data pack.

Safe

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Key lines of enquiry: S1

S1. How do systems, processes and practices keep people safe and safeguarded from abuse?

Report sub-heading: **Mandatory training**

Prompts	Professional standard	Tier 4 guidance
<ul style="list-style-type: none"> S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? S1.5 Do staff receive effective training in safety systems, processes and practices? 	<ul style="list-style-type: none"> Providers should have regard to the statutory guidance 'Working Together to Safeguard Children'. This guidance references the intercollegiate document <i>Safeguarding Children and Young People: Roles and competencies for Health Care Staff</i> published in March 2014, which sets out that as a minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers should be trained to level 2 and all clinical staff clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or 	<ul style="list-style-type: none"> Is there a structured induction programme that all staff complete when they commence employment? What are the mandatory training rates for staff working in these services and where are the gaps? <ul style="list-style-type: none"> With regards to neonatal sepsis training: Is there a policy for neonatal sepsis management and are staff aware of it? Have staff had training for neonatal sepsis? Do they know of the Trust's Neonatal Sepsis policy?

	<p>young person should be trained to level 3 in safeguarding.</p> <ul style="list-style-type: none"> • Education on Spotting the Sick Child as should be promoted for all staff • Neonatal sepsis NICE Guideline - Neonatal infection (early onset): antibiotics for prevention and treatment 	
Report sub-heading: Safeguarding		
<ul style="list-style-type: none"> • S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.2 How do systems, processes and practices protect people from abuse, neglect, harassment and breaches of their dignity and respect? How are these monitored and improved? • S1.3 How are people protected from discrimination, which might amount to abuse or cause psychological harm? This includes harassment and discrimination in relation to protected characteristics under the Equality Act. • S1.4 How is safety promoted in recruitment practice staff support arrangements, disciplinary procedures, and ongoing checks? (For example Disclosure and Barring Service checks). 	<ul style="list-style-type: none"> • Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014) • HM Government: Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. March 2015 • Female genital mutilation multi-agency practice guidelines published in 2016 • DH Female Genital Mutilation and Safeguarding: Guidance for professionals March 2015 • Guidelines for physicians on the detection of child sexual exploitation (RCP, November 2015) • Providers should have regard to the statutory guidance 'Working Together 	<ul style="list-style-type: none"> • Do staff know how to identify and report abuse and neglect? • Are all clinical staff working directly with children level 3 safeguarding trained? • Is there safeguarding supervision (nurses) and peer review (doctors) in place for all staff? • Is there an identifiable lead responsible for co-ordinating communication for children at risk of safeguarding issues? • Do staff have an awareness of CSE and understand the law to detect and prevent maltreatment of children <ul style="list-style-type: none"> – how do staff identify and respond to possible CSE offences? – are risk assessments used/in place? – what safeguarding actions are taken to protect possible victims? – are timely referrals made?

<ul style="list-style-type: none"> • S1.5 Do staff receive effective training in safety systems, processes and practices? • S1.6 Are there arrangements to safeguard adults and children from abuse and neglect that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures, including working in partnership with other agencies? • S1.7 Do staff identify adults and children at risk of, or suffering, significant harm? How do they work in partnership with other agencies to ensure they are helped, supported and protected? 	<p>to Safeguard Children'. (2015) and Facing the Future (RCPCH, 2015) Standard 10</p> <ul style="list-style-type: none"> • Providers should have regard to safeguarding children from abuse linked to faith or belief https://www.gov.uk/government/publications/national-action-plan-to-tackle-child-abuse-linked-to-faith-or-belief • This guidance references the intercollegiate document <i>Safeguarding Children and Young People: Roles and competencies for Health Care Staff</i> published in March 2014, which sets out that as a minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers should be trained to level 2 and all clinical staff clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level 3 in safeguarding. • Guidance for physicians on the detection of child sexual exploitation. RCP 2015 <p>The above guidance should be considered together with other relevant</p>	<ul style="list-style-type: none"> - Is there individualised and effective multi-agency follow up? - are leaflets available with support contact details? • All children, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report (Facing the future 2015) • What wider safeguarding protocol/guidance is in place - how are safeguarding issues talked about, who manages them, are lessons learned etc.? • Does the service ensure that all staff are trained to appropriate level set out in the intercollegiate document <i>Safeguarding Children and Young People: Roles and competencies for Health Care Staff</i> published in March 2014 and are familiar with Government guidance 'Working Together to Safeguard Children.
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	<p>safeguarding guidance including (but not limited to):</p> <ul style="list-style-type: none"> • Working together to safeguard children: HM Gov. 2015 • FGM Mandatory reporting of FGM in healthcare • https://www.gov.uk/government/news/doctors-and-nurses-required-to-report-fgm-to-police 	<ul style="list-style-type: none"> • Have there been any local safeguarding/serious case reviews? If so, how have they been responded to? • Are there arrangements in place to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM) • Providers should be aware of the most recent multi-agency practice guidelines published in 2014 to support front line staff including health professionals in safeguarding children and protecting adults from the abuses associated with FGM. See also FGM guidance for professionals on the NHS Choices website • What system is in place to check whether all babies are subject to a child protection plan? • What are the trusts/ departmental abduction and safeguarding policy? • What are the arrangements for chaperones? What training have staff received? <ul style="list-style-type: none"> – Are there key codes on the doors?
<p>Report sub-heading: Cleanliness, infection control and hygiene</p>		
<ul style="list-style-type: none"> • S1.1 How are safety and safeguarding systems, processes and practices 	<ul style="list-style-type: none"> • NICE QS61 Statement 3: People receive healthcare from healthcare 	<ul style="list-style-type: none"> • Observations – is the ward visibly clean, clutter free? Do staff adhere to

<p>developed, implemented and communicated to staff?</p> <ul style="list-style-type: none"> • S1.8 How are standards of cleanliness and hygiene maintained? Are there reliable systems in place to prevent and protect people from a healthcare-associated infection? 	<p>workers who decontaminate their hands immediately before and after every episode of direct contact or care.</p> <ul style="list-style-type: none"> • NICE QS61 Statement 4: People who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. • NICE QS61 Statement 5: People who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal as soon as it is no longer needed. 	<p>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?</p> <ul style="list-style-type: none"> • How does the service educate parents/carers on infection control practice? • Hand hygiene audit results? • What are the Nascomial infection rates (NNAP)?
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Report sub-heading: **Environment and equipment**

<ul style="list-style-type: none"> • S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.9 Do the design, maintenance and use of facilities and premises keep people safe? • S1.10 Do the maintenance and use of equipment keep people safe? 	<ul style="list-style-type: none"> • All equipment must conform to the relevant safety standards and be regularly serviced in accordance with manufacture guidance. Electrical equipment must be PAT tested. • Resuscitation drugs and equipment, including an appropriate defibrillator, will be routinely available at all sites where babies are to be anaesthetised • HBN 09-03: Neonatal Units 	<ul style="list-style-type: none"> • Is specialist equipment for neonates, including that required for resuscitation, available and fit for purpose? • Are there up-to-date standard operating procedures in place specifically for services for babies?
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<ul style="list-style-type: none"> S1.11 Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.) 	<ul style="list-style-type: none"> Standards for Children's surgery – The Royal College of Surgeons, 2013 	
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Key line of enquiry: S2

S2. How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?

Report sub-heading: **Assessing and responding to patient risk**

Prompts	Professional standard	Tier 4 guidance
<ul style="list-style-type: none"> S2.5 Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? S2.6 How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges? Are staff able to seek support from senior staff in these situations? 	<ul style="list-style-type: none"> Sepsis: recognition, diagnosis and early management (NICE Guideline 51) British Association of Perinatal Medicine, Newborn Early Warning Trigger and Track (NEWTT) http://www.bapm.org/publications/documents/guidelines/NEWTT%20framework%20final%20for%20website.pdf NICE Quality statement QS4: In-utero and postnatal transfers for neonatal special, high-dependency, intensive and surgical care follow perinatal network guidelines and care pathways that are integrated with other maternity and newborn network guidelines and pathways Quality statement 4: Neonatal transfer services. Quality statement: Neonatal 	<ul style="list-style-type: none"> Use of neonatal early warning trigger and track NEWTT (or equivalent) / escalation process. How is compliance monitored? Is there an escalation / transfer policy for seriously unwell babies? What are the arrangements for the care of babies undergoing surgical procedures? Does the unit comply with PICS? Are these reported as an incident and how are they monitored? Is there a clear evidence of use of a screening tool for sepsis in all admission areas? Is there evidence of network arrangements to provide a 24-hour, 7 days a week neonatal transport service with a single telephone contact?

	<p>transfer services provide babies with safe and efficient transfers to and from specialist neonatal care</p> <ul style="list-style-type: none"> • Patients and their families are given clear information on discharge from the service and are able to make contact with a healthcare professional for advice and support following discharge. Standards for Children's surgery – The Royal College of Surgeons, 2013. • High Dependency Care RCPCH RCPCH-PICS 2015 defines Level 1,2,3 Paediatric Critical care (PCC) units and sets out standards for care in Level 1 and 2 units including network working and commissioning arrangements for England. • RCEM Clinical Standards for Sepsis • NICE guideline [NG51] Sepsis: recognition, diagnosis and early management 	<ul style="list-style-type: none"> • Is there evidence of use of a sepsis bundle for the management of sepsis? Does this incorporate a safe and effective escalation process? • Has the treatment been delivered within the recommended sepsis pathway timelines? E.g. Time to Antibiotics • Are staff provided with a debrief/ other support after involvement in aggressive or violent incidents? • How do leaders ensure that employees who are involved in the performance of invasive procedures develop shared understanding and are educated in good safety practice, as set out in the national standards? • Have managers ensured that there is a plan in place to develop local Safety Standards for Invasive Procedures using the national Safety Standards for Invasive Procedures. Have they assessed the need for these against all invasive procedures carried out?
<p>Report sub-heading: Nurse staffing</p>		
<ul style="list-style-type: none"> • S2.1 How are staffing levels and skill mix planned and reviewed so that people receive 	<ul style="list-style-type: none"> • DH Toolkit for Neonatal Services (2009) and the British Association of Perinatal Medicine (BAPM) Optimal 	<ul style="list-style-type: none"> • Do Neonatal Nurse staffing comply with BAPM standards: <ul style="list-style-type: none"> – 1:1 for Intensive care (NICU)

<p>safe care and treatment at all times and staff do not work excessive hours?</p> <ul style="list-style-type: none"> • S2.2 How do actual staffing levels and skill mix compare with the planned levels? Is cover provided for staff absence? • S2.3 Do arrangements for using bank, agency and locum staff keep people safe at all times? • S2.4 How do arrangements for handovers and shift changes ensure that people are safe? • S2.7 How is the impact on safety assessed and monitored when carrying out changes to the service or the staff? 	<ul style="list-style-type: none"> • Arrangements for Neonatal intensive Care Units in the UK including guidance on their Medical Staffing: A Framework for Practice (2014) • Standards for assessing, measuring and monitoring vital signs in infants, children and young people: RCN guidance for nurses working with children and young people 	<ul style="list-style-type: none"> - 1:2 for high dependency (HDU) - 1:4 for Special care (SC) • Are nursing levels recorded twice daily, captured on a system such as BadgerNet? Are network figures available to inspectors? • Is there a minimum of 70:30 registered to unregistered staff with a higher proportion of registered nurses? • Is there a minimum of 70:30 nurses working on the neonatal unit that hold a recognised neonatal qualification? • Is there a reliance on shift rotas/ bank staff in babies? – do bank/locum staff have appropriate neonatal training? • Is there a minimum of two registered children’s nurses at all times, of which at least one is QIS? [DH Toolkit] • Is there is a nursing coordinator on every shift in addition to those providing direct clinical care?[DH Toolkit] • Where a unit provides surgical services, is there a nurse / midwife with neonatal surgical experience who has clinical leadership responsibility for nursing care of babies needing surgery? [DH Toolkit]
<p>Report sub-heading: Medical staffing</p>		
<ul style="list-style-type: none"> • S2.1 How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times and staff do not work excessive hours? 	<ul style="list-style-type: none"> • DH Toolkit for Neonatal Services (2009) • British Association of Perinatal Medicine (BAPM) Optimal 	<ul style="list-style-type: none"> • If the service has a SCBU, are the following available: <ul style="list-style-type: none"> - 24 hour availability from a consultant paediatrician

<ul style="list-style-type: none"> • S2.2 How do actual staffing levels and skill mix compare with the planned levels? Is cover provided for staff absence? • S2.3 Do arrangements for using bank, agency and locum staff keep people safe at all times? • S2.4 How do arrangements for handovers and shift changes ensure that people are safe? • S2.7 How is the impact on safety assessed and monitored when carrying out changes to the service or the staff? 	<p><u>Arrangements for Neonatal intensive Care Units in the UK including guidance on their Medical Staffing: A Framework for Practice (2014).</u></p>	<ul style="list-style-type: none"> - 24 hour cover of resident ST4 + or advanced neonatal nurse practitioner (ANNP) - 24 hour cover for provision of direct care (ST1-3 or ANNP) • If the service provides short term intensive care are the following available: <ul style="list-style-type: none"> - 24 hour availability of a consultant paediatrician with experience and training in neonatal care - 24 hour cover of ST+ or ANNP to respond immediately to neonatal emergencies - 24 hour cover for provision of direct care with sole responsibility for the neonatal service (ST1-3 or ANNP) ➤ If the service provides intensive care units, are the following available: <ul style="list-style-type: none"> - 24 hour availability of consultant neonatologist whose principal duties are to the neonatal unit - 24 hour cover of resident ST4+ or ANNP for sole cover of the neonatal service - 24 hour cover for provision of direct care with sole responsibility
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to the neonatal service (ST1-3 or ANNP)

Key line of enquiry: **S3**

S3. Do staff have all the information they need to deliver safe care and treatment to people?

Prompts	Professional standard	Tier 4 guidance
Report sub-heading: Records		
<ul style="list-style-type: none"> S3.1 Are people’s individual care records, including clinical data, written and managed in a way that keeps people safe? S3.2 Is all the information needed to deliver safe care and treatment available to relevant staff in a timely and accessible way? (This may include test and imaging results, care and risk assessments, care plans and case notes.) S3.3 When people move between teams, services and organisations (which may include at referral, discharge, transfer and transition), is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols? S3.4 How well do the systems that manage information about people who use services support staff, carers and partner agencies to deliver safe care and treatment? (This includes coordination between different 	<ul style="list-style-type: none"> Records management code of practice for health and social care NICE QS15 Statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. Records are clear, accurate and legible. All concerns and actions taken as a result are recorded. Information relevant to keeping a child or young person safe is recorded and available to other clinicians providing care to them. GMC guidance Primary care colleagues receive timely and accurate discharge information in order to support the patient in primary care Standards for Children’s surgery – The Royal College of Surgeons, 2013 	<ul style="list-style-type: none"> Are specific neonatal care assessments used? What information sharing systems are in place with other relevant departments, such as maternity? Are there systems in place to flag up potential medical needs from the mother’s medical records? Are there systems to flag on records where a baby has particular needs including child protection and is this widely understood? Does the service ensure use of Personal Child Health Record (PCHR) (referred to as red books) and recognised growth charts? Does the service require or encourage parents/guardians to bring these books to each hospital appointment or admission in order to facilitate sharing of child health records and hospital admissions?

<p>electronic and paper-based systems and appropriate access for staff to records.)</p>	<ul style="list-style-type: none"> • NICE QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record 	<ul style="list-style-type: none"> • How is discharge communicated to GPs? How soon after discharge does this occur? • Are care summaries sent to the person's GP on discharge to ensure continuity of care within the community? • Do GPs have direct access to records? Can they speak to a consultant/SpR for advice on the phone? • When people are prescribed an antimicrobial do they have the clinical indication, dose and duration of treatment documented in their clinical record?
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Key line of enquiry: S4

S4. How does the provider ensure the proper and safe use of medicines, where the service is responsible?

Prompts	Professional standard	Tier 4 guidance
<p>Report sub-heading: Medicines</p>		
<ul style="list-style-type: none"> • S4.1 How are medicines and medicines related stationery managed (that is, ordered, transported, stored and disposed of safely and securely)? (This includes medical gases and emergency medicines and equipment.) • S4.2 Are medicines appropriately prescribed, administered and/or supplied to people in line with the relevant legislation, current 	<ul style="list-style-type: none"> • Nursing and Midwifery Council NMC - Standards for Medicine Management • NICE QS61 Statement 1: People are prescribed antibiotics in accordance with local antibiotic formularies. 	<ul style="list-style-type: none"> • Are allergies clearly documented in the prescribing document used? • Is the baby's weight clearly documented and are all prescriptions appropriate for the baby's weight? • Are nursing staff (and midwives where applicable) aware of policies on administration of controlled drugs as per

<p>national guidance or best available evidence?</p> <ul style="list-style-type: none"> • S4.3 Do people receive specific advice about their medicines in line with current national guidance or evidence? • S4.4 How does the service make sure that people receive their medicines as intended, and is this recorded appropriately? • S4.5 Are people's medicines reconciled in line with current national guidance on transfer between locations or changes in levels of care? • S4.6 Are people receiving appropriate therapeutic drug and physical health monitoring with appropriate follow-up in accordance with current national guidance or evidence? • S4.7 Are people's medicines regularly reviewed including the use of 'when required' medicines? • S4.8 How does the service make sure that people's behaviour is not controlled by excessive or inappropriate use of medicines? 	<ul style="list-style-type: none"> • NICE QS 61: People are prescribed antibiotics in accordance with local antibiotic formularies. • RCN 2013, Standards for the weighing of infants, children and young people in the acute health care setting • NICE QS121 Statement 4: People in hospital who are prescribed an antimicrobial have a microbiological sample taken and their treatment reviewed when the results are available • Start Smart then Focus: Antimicrobial Stewardship Toolkit 	<p>the Nursing and Midwifery Council – Standards for Medicine Management?</p> <ul style="list-style-type: none"> • Are there local microbiology protocols for the administration of antibiotics and are prescribers using them? • When people are prescribed an antimicrobial do they have a microbiological sample taken and is their treatment reviewed when results are available?
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Key line of enquiry: **S5 & S6**

S5. What is the track record on safety?

S6. Are lessons learned and improvement made when things go wrong?

Prompts	Professional standard	Tier 4 guidance
Report sub-heading: Incidents		
<ul style="list-style-type: none"> • S5.1 What is the safety performance over time? 	<ul style="list-style-type: none"> • A never event is a <i>serious, wholly preventable</i> patient safety incident that has the <i>potential to cause serious</i> 	<ul style="list-style-type: none"> • Never Events: “Never events are serious, largely preventable patient safety incidents that should not occur if

<ul style="list-style-type: none"> • S5.2 How does safety performance compare with other similar services? • S5.3 How well safety is monitored using information from a range of sources (including performance against safety goals where appropriate)? • S6.1 Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate? • S6.2 What are the arrangements for reviewing and investigating safety and safeguarding incidents and events when things go wrong? Are all relevant staff, services, partner organisations and people who use services involved in reviews and investigations • S6.3 How are lessons learned, and themes identified and is action taken as a result of investigations when things go wrong? • S6.4 How well is the learning from lessons shared to make sure that action is taken to improve safety? Do staff participate in and learn from reviews and investigations by other services and organisations? • S6.5 How effective are the arrangements to respond to relevant external safety alerts, recalls, inquiries, investigations or reviews? 	<p><i>patient harm or death, has occurred in the past and is easily recognisable and clearly defined.</i></p> <ul style="list-style-type: none"> ➤ Revised never events policy and framework (2015) ➤ Never events list 2015/16 ➤ Never Events List 2015/15 - FAQ <ul style="list-style-type: none"> • Serious Incidents (SIs) should be investigated using the Serious Incident Framework 2015. • Duty of Candour: As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. • Child deaths should be reported through the Child Death Overview Panel ref 'Working Together to Safeguard Children' 	<p>the available preventative measures have been implemented”</p> <ul style="list-style-type: none"> • Have the Trust reported any Never Events? • The criteria within the Serious Incident Framework describes the general circumstance in which providers and commissioners should expect Serious Incidents to be reported. • How many safeguarding incidents have been reported? Is there an audit trail of evidence and action taken? Were the CQC notified? What other agencies were involved? (e.g. police, LA) • Where there are safeguarding concerns, are Individual Management Reviews or Root Cause Analyses completed to contribute to a multi-agency Serious Case Review? • How is learning disseminated? – Any evidence of change to practice as a result? • How does the neonatal service respond to national patient safety alerts? • How regularly does the service hold mortality and morbidity meetings when these occur? Who attends? Are they minuted? • How is learning disseminated for those unable to attend? How do reviews from safety events involving babies feed in to service improvement?
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		<ul style="list-style-type: none"> Is there evidence in incident investigations that duty of candour has been applied?
Report sub-heading: Safety Thermometer		
<ul style="list-style-type: none"> S5.1 What is the safety performance over time? S5.2 How does safety performance compare with other similar services? S5.3 How well safety is monitored using information from a range of sources (including performance against safety goals where appropriate)? 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Is a neonate specific safety thermometer (or equivalent) in use – for example, early warning trigger and track NEWTT (or equivalent) / escalation process? If so, does the service take appropriate action as a result of the findings?

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Key line of enquiry: **E1**

E1. Are people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Prompts

Professional standard

Tier 4 guidance

Report sub-heading: **Evidence-based care and treatment**

- E1.1 Are people's physical, mental health and social needs holistically assessed, and

- Which accreditation schemes are participated in (e.g. You're Welcome

<p>is their care, treatment and support delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes?</p> <ul style="list-style-type: none"> • E1.2 What processes are in place to ensure there is no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions? • E1.3 How is technology and equipment used to enhance the delivery of effective care and treatment and to support people's independence? • E1.4 Are the rights of people subject to the Mental Health Act 1983 (MHA) protected and do staff have regard to the MHA Code of Practice? • E1.7 Are people told when they need to seek further help and advised what to do if their condition deteriorates? 	<ul style="list-style-type: none"> • 'You're Welcome', the Department of Health's quality criteria for young people friendly health services. • Unicef statements to assist services in the implementation of Baby Friendly standards. • Compliance with BAPM/ standards for neonatal units http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf • Compliance with NICE standards for neonatal units Neonatal specialist care Guidance and guidelines NICE • End of life care for infants, children and young people with life-limiting conditions: planning and management • NICE QS 75 Neonatal infection: covers the use of antibiotics to prevent and treat infection in a new born baby from birth to 28 days in primary (including community) and secondary care • NICE QS57 Jaundice in newborn babies under 28 days: covers diagnosis and treating jaundice, which is caused by high levels of bilirubin in the blood in new born babies (neonates). It aims to detect and or prevent high levels of bilirubin. 	<p>(DH), Baby Friendly (Unicef), BLISS baby charter) and what action has been taken as a result?</p> <ul style="list-style-type: none"> • Compliance with national audit and benchmarking and use of findings – NNAP, MBRRACE • What local audits are undertaken to indicate compliance with guidelines? • Are relevant NICE guidelines for and quality standards followed? <p>NB: In assessing whether NICE guidance is followed, take the following into account:</p> <ul style="list-style-type: none"> • Details of the provider's Clinical Audit programme to support and monitor implementation of NICE guidance; • Details of additional prescribing audits that may be completed by junior doctors on rotation. • Utilisation of NICE implementation support tools such as the baseline assessment tools. • A Provider submission demonstrating good practice to the NICE shared learning database. NICE checks that the examples are in line with their recommendations and quality statements.
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		<ul style="list-style-type: none"> • Participation in National benchmarking clinical audits. • Do prescribers in secondary care use electronic prescribing systems which link the indication with the antimicrobial prescription? • Do staff handovers routinely refer to the psychological and emotional needs of the patient's relatives / carers? • Is there a bereavement care plan or pathway for families? Does this cover: <ul style="list-style-type: none"> ○ Communication with parents ○ Continuity and consistency of approach ○ Parent-led family involvement
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Report sub-heading: **Nutrition and hydration**

<ul style="list-style-type: none"> • E1.5 How are people's nutrition and hydration needs (including those related to culture and religion) identified, monitored and met? Where relevant, what access is there to dietary and nutritional specialists to assist in this? 	<ul style="list-style-type: none"> • NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. • The Baby Friendly Initiative Research Interventions that promote breastfeeding Baby Friendly accreditation increases breastfeeding rates 	<ul style="list-style-type: none"> • Is age appropriate nutrition provided? • Where relevant do baby's care plans include an appropriate nutrition and hydration assessment and management plan?
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Report sub-heading: **Pain relief**

<ul style="list-style-type: none"> E1.6 How is a person's pain assessed and managed, particularly for those people where there are difficulties in communicating? 	<ul style="list-style-type: none"> http://www.rcoa.ac.uk/document-store/audit-recipe-book-section-9-paediatrics-2012 <u>Guidance from the Association of Pediatric Anesthetists of Great Britain and Ireland Good Practice in Postoperative and Procedural Pain, 2nd Edition, 2012 Association of Paediatric Anaesthetists of Great Britain and Ireland</u> 	<ul style="list-style-type: none"> Is there an MDT approach (as appropriate) to pain management e.g. following surgery? Identify any pain management processes in place. Where relevant do children and young people's care plans include an appropriate pain assessment and management plan? Is there an adequately resourced and staffed acute pain team which covers the needs of babies?
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Key line of enquiry: **E2**

E2. How are people's care and treatment outcomes monitored and how do they compare with other similar services?

Prompts	Professional standard	Tier 4 guidance
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Report sub heading: **Patient outcomes**

<ul style="list-style-type: none"> E2.1 Is information about the outcomes of people's care and treatment (both physical and mental where appropriate) routinely collected and monitored? E2.2 Does this information show that the intended outcomes for people are being achieved? 		<ul style="list-style-type: none"> Is the service regularly reviewing the effectiveness of care and treatment through local audit and national audit? Are there audits that the service does not contribute to? How do the national clinical audits/ confidential enquiries results compare with other comparable providers? For example: <ul style="list-style-type: none"> Network wide audits National Neonatal Audit (HQIP)
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<ul style="list-style-type: none"> • E2.3 How do outcomes for people in this service compare with other similar services and how have they changed over time? • E2.4 Is there participation in relevant quality improvement initiatives, such as local and national clinical audits, benchmarking, (approved) accreditation schemes, peer review, research, trials and other quality improvement initiatives? Are all relevant staff involved in activities to monitor and use information to improve outcomes? 		<ul style="list-style-type: none"> - Maternal, new-born and infant clinical outcome review programme (HQIP) • How does their surgery results compare with national benchmarks such as Dendrite and BAPS audits? Do they have regular audit meetings to discuss their compliance? • Atlas of Variation
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Key line of enquiry: E3

E3. How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?

Prompts	Professional standard	Tier 4 guidance
Report sub heading: Competent staff		
<ul style="list-style-type: none"> • E3.1 Do people have their assessed needs, preferences and choices met by staff with the right skills and knowledge? • E3.2 How are the learning needs of all staff identified? Do staff have appropriate training to meet their learning needs to cover the scope of their work and is there protected time for this training? • E3.3 Are staff encouraged and given opportunities to develop? • E3.4 What are the arrangements for supporting and managing staff to deliver effective care and treatment? (This includes one-to-one meetings, appraisals, 	<ul style="list-style-type: none"> • Surgeons and anaesthetists demonstrate evidence of appropriate resuscitation training to a level appropriate to their role and clinical responsibility (in accordance with Resus Council UK and Royal College (Surgeon and Anaesthetists) guidelines. Standards for Children's surgery – The Royal College of Surgeons, 2013. • At least one member of medical staff in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need. Royal College of Nursing 	<ul style="list-style-type: none"> • Do all anaesthetists / theatre/ recovery staff who may care for babies have up-to-date competencies? • Are sufficient staff trained, and maintain competencies, in life support on any one shift? Is this is to advanced levels e.g. Newborn Life Support (NLS) or equivalent? • Are surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in babies? Do they have appropriate training and competence to handle to emergency surgical care of babies, including those

<p>coaching and mentoring, clinical supervision and revalidation.)</p> <ul style="list-style-type: none"> • E3.5 How is poor or variable staff performance identified and managed? How are staff supported to improve? • E3.7 Are volunteers recruited where required, and are they trained and supported for the role they undertake? 	<ul style="list-style-type: none"> • guidance on Defining staffing levels for children and young people's services • NICE Quality standard: Skilled and multidisciplinary staff • NICE guideline CG149 Neonatal infection (early onset): antibiotics for prevention and treatment • NICE Quality standard QS75 Neonatal infection • NICE QS121 Statement 5: Individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber, team, organisation and commissioner level. • Start Smart then Focus: Antimicrobial Stewardship Toolkit 	<p>with life-threatening conditions who cannot be transferred or who cannot wait until a designated surgeon or anaesthetist is available? Report only by exception – i.e. if there are particular concerns</p> <ul style="list-style-type: none"> • Is there evidence of local arrangements to ensure specialist neonatal staff are compliant with competency levels as described by the DH toolkit (2009)? • Is there evidence of local arrangements to provide a multidisciplinary service, trained and competent in the care of babies? • Are there corporate/hospital policies in place that detail resuscitation training requirements? • Are there policies in place for: <ul style="list-style-type: none"> - The ability to manage a critically ill baby for an extended period when there are delays in retrieval from a NICU team? - The ability to transfer a baby with a time sensitive condition (such as intracranial haematoma)? • Is every baby referred with an acute medical problem seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged?
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		<ul style="list-style-type: none">• Does the neonatal assessment unit have access to the opinion of a consultant neonatologist at all times?• Do the neonatal inpatient units adopt an attending consultant or 'consultant of the week' system?• Are specialist neonatologists available for immediate telephone advice for acute problems for all specialties, and for all paediatricians (Facing the Future 2015)• Have staff in the department received training on neonatal sepsis<ul style="list-style-type: none">- Screening- Management- Trust policy• Where failure in the neonatal sepsis protocol has been identified have staff been given support and education?• Do individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber level?• What training do staff receive in bereavement and how can they demonstrate their knowledge of this to you?• Are staff supported to access bereavement training?
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Key line of enquiry: E4

E4. How well do staff, teams and services within and across organisations work together to deliver effective care and treatment?

Prompts	Professional standard	Tier 4 guidance
Report sub-heading: Multidisciplinary working		
<ul style="list-style-type: none"> E4.1 Are all necessary staff, including those in different teams, services and organisations, involved in assessing, planning and delivering care and treatment? E4.2 How is care delivered and reviewed in a coordinated way when different teams, services or organisations are involved? E4.3 How are people assured that they will receive consistent coordinated, person-centred care and support when they use, or move between different services? E4.4 Are all relevant teams, services and organisations informed when people are discharged from a service? Where relevant, is discharge undertaken at an appropriate time of day and only done when any necessary ongoing care is in place? 	<ul style="list-style-type: none"> PHSO: A report of investigations into unsafe discharge from hospital Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline 27) Guidelines for the Provision of Anaesthesia Services (GPAS) Guidelines for the Provision of Paediatric Anaesthesia Services 2017 Consultants work within the limits of their professional competence and where there are unexpected circumstances requiring that they act beyond their practised competences, support is available from colleagues within the service network (description of support) Standards for Children's surgery – The Royal College of Surgeons, 2013 Facing the Future Together for Child Health sets out eleven standards for reducing hospital attendance by 	<ul style="list-style-type: none"> Is there access to paediatric pharmacy advice 24/7? How do adult and CYP services work together to share information? Are there neonatal MDT meeting and ward rounds? How does the service ensure that the objectives of The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients has been implemented? Are all team members aware of who has overall responsibility for each individual's care? When babies are discharged from a service, are there clear mechanisms for sharing appropriate information with their GP and other relevant professionals and to ensure that the family fully understand what is happening and any next steps? Is information shared in timely way?

	<p>working more closely with primary care. services</p> <p>www.rcpch.ac.uk/facingthefuture</p> <ul style="list-style-type: none"> • Bringing networks to life – RCPCH 2012 • PHSO: A report of investigations into unsafe discharge from hospital 	<ul style="list-style-type: none"> • What access is there to advice from tertiary neonatal services in and out of hours and is this sufficient? • What discharge information and support is available when babies are transferred back to the service care? • What are the transfer arrangements? • Are there established links with Children’s Social Services teams? • Is there evidence of multi-disciplinary/ interagency working when required?
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Report sub-heading: **Seven-day services**

<ul style="list-style-type: none"> • E4.5 How are high-quality services made available that support care to be delivered seven days a week and how is their effect on improving patient outcomes monitored? 	<ul style="list-style-type: none"> • http://www.rcpch.ac.uk/news/247-consultant-delivered-care-%E2%80%98must%E2%80%99-effective-nhs-says-new-report provides the findings of a survey of RCPCH members examining the changing nature of pediatric consultant work patterns. • RCPCH Workforce census 2013 provides benchmark data Workforce census 2015 RCPCH 	<ul style="list-style-type: none"> • Do hospital inpatients have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and pathology?
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Key line of enquiry: **E5**

E5. How are people supported to live healthier lives and where the service is responsible, how does it improve the health of its population?

Prompts	Professional standard	Tier 4 guidance
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Report sub-heading: **Health promotion**

- E5.1 Are people identified who may need extra support? This includes:
 - people in the last 12 months of their lives
 - people at risk of developing a long-term condition
 - carers
- E5.2 How are people involved in regularly monitoring their health, including health assessments and checks, where appropriate and necessary
- E5.3 Are people who use services empowered and supported to manage their own health, care and wellbeing and to maximise their independence?
- E5.4 Where abnormalities or risk factors are identified that may require additional support or intervention, are changes to people's care or treatment discussed and followed up between staff, people and their carers where necessary?
- E5.5 How are national priorities to improve the population's health supported? (For example, smoking cessation, obesity, drug and alcohol dependency, dementia and cancer.)

[Healthy Child Programme: Pregnancy and the First 5 Years of Life](#) This guidance focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

Key line of enquiry: E6

E6. Is consent to care and treatment always sought in line with legislation and guidance?

Prompts

Professional standard

Tier 4 guidance

Report sub-heading: **Consent, Mental Capacity Act and DOLs**

<ul style="list-style-type: none"> • E6.1 Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and other relevant national standards and guidance? • E6.2 How are people supported to make decisions in line with relevant legislation and guidance? • E6.3 How and when is possible lack of mental capacity to make a particular decision assessed and recorded? • E6.4 How is the process for seeking consent monitored and reviewed to ensure it meets legal requirements and follows relevant national guidance? • E6.5 When people lack the mental capacity to make a decision, do staff ensure that best interests decisions are made in accordance with legislation? • E6.6 How does the service promote supportive practice that avoids the need for physical restraint? Where physical restraint may be necessary, how does the service ensure that it is used in a safe, proportionate, and monitored way as part of a wider person centred support plan? • E6.7 Do staff recognise when people aged 16 and over and who lack mental capacity are being deprived of their liberty, and do they seek authorisation to do so when they consider it necessary and proportionate? 	<ul style="list-style-type: none"> • Consent: patients and doctors making decisions together (GMC) • Consent - The basics (Medical Protection) • Department of Health reference guide to consent for examination or treatment • BMA Consent Toolkit • GMC Consent: patients and doctors making decisions together • http://www.medicalprotection.org/uk/resources/factsheets/england/england-factsheets/uk-eng-consent-the-basics 	<ul style="list-style-type: none"> • What arrangements are in place if parents are not thought capable of providing consent? (Include consenting for operative procedures)
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Caring

By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.

Key line of enquiry: C1, C2 & C3

C1. How does the service ensure that people are treated with kindness, dignity, respect and compassion, and that they are given emotional support when needed?

C2. How does the service support people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible?

C3. How is people's privacy and dignity respected and promoted?

Generic prompts	Professional Standard	Additional prompts
Report sub-heading: Compassionate care		
<ul style="list-style-type: none"> • C1.1 Do staff understand and respect the personal, cultural, social and religious needs of people and how these may relate to care needs, and do they take these into account in the way they deliver services? Is this information recorded and shared with other services or providers? • C1.2 Do staff take the time to interact with people who use the service and those close to them in a respectful and considerate way? • C1.3 Do staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them? • C1.4 Do staff raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes? • C3.1 How does the service and staff make sure that people's privacy and dignity needs are understood and always respected, including during physical or intimate care and examinations? • C3.2 Do staff respond in a compassionate, timely and appropriate way when people experience physical pain, discomfort or emotional distress? 	<ul style="list-style-type: none"> • DH Toolkit for Neonatal Services (2009) <ul style="list-style-type: none"> ○ How do staff ensure every baby is treated with dignity and respect? For example by: <ul style="list-style-type: none"> ○ promoting and encouraging appropriate positioning ○ managing clinical interventions to minimise stress, avoid pain and conserve energy. ○ ensuring noise and light levels are managed to minimise stress. ○ ensuring appropriate clothing is used at all times, taking into account parents' choice. ○ ensuring privacy is respected and promoted as appropriate to the baby's condition. • There must be frequent communication with the family throughout the hospital stay, at all times ensuring patient privacy and confidentiality. • Standards for Children's surgery – The Royal College of Surgeons, 2013 	<ul style="list-style-type: none"> • Observed staff/ patient and carer interactions – including whether privacy and dignity, confidentiality preserved • How do staff make sure dignity is maintained as far as possible during transport in and to and from a vehicle? • How do staff respond to families who might be <ul style="list-style-type: none"> ○ frightened ○ confused ○ phobic about medical procedures or any aspect of their care? • Can the service provide you with any examples of how they ensure they provide good care? • Are there any examples of surveys they undertake locally on care and experience?

Report sub-heading: Emotional support

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| <ul style="list-style-type: none">• C1.5 Do staff understand the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially?• C1.6 Are people given appropriate and timely support and information to cope emotionally with their care, treatment or condition? Are they advised how to find other support services?• C2.7 What emotional support and information is provided to those close to people who use services, including carers, family and dependants? | <ul style="list-style-type: none">• NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.• Sands Guidelines - Pregnancy loss and death of a baby | <ul style="list-style-type: none">• Do parents feel confident leaving the ward and their baby's care with the staff on the ward at the time?• How do staff recognise and support the broader emotional wellbeing of babies and their carers and those close to them?• What support is available for parents and others close to the babies who have received bad news? Is there a bereavement or counselling service available?• If a parent or those close to babies becomes distressed in an open environment, how do staff assist them to maintain their privacy and dignity?• How is appropriate specialist bereavement support provided that meets the individual circumstances of families?• How do staff ensure that they deliver parent-led care, tailored to their individual needs and wishes? How are these wishes recorded, and other staff made aware of this?• Does the family have time with the baby they have lost? What procedures are in place to facilitate this? |
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		<ul style="list-style-type: none"> • Do they have cooled cots to allow the family to have time with their baby in their home? Does the service have a clear procedure in place to enable this, which is understood by all staff? Are all bereaved families informed that this is an option for them?
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Report sub-heading: **Understanding and involvement of patients and those close to them**

<ul style="list-style-type: none"> • C2.1 Do staff communicate with people so that they understand their care, treatment and condition and any advice given? • C2.2 Do staff seek accessible ways to communicate with people when their protected equality or other characteristics make this necessary? • C2.3 How do staff make sure that people who use services and those close to them are able to find further information, including community and advocacy services, or ask questions about their care and treatment? How are they supported to access these? • C2.4 Are people empowered and supported, where necessary, to use and link with support networks and advocacy, so that it will have a positive impact on their health, care and wellbeing? • C2.5 Do staff routinely involve people who use services and those close to them (including carers and dependants) in 	<ul style="list-style-type: none"> • DH Toolkit for Neonatal Services (2009) <ul style="list-style-type: none"> ○ Are parents are encouraged and supported to participate in their baby's care at the earliest opportunity, including: <ul style="list-style-type: none"> ○ regular skin-to-skin care; ○ providing comforting touch and comfort holding, particularly ○ during painful procedures; ○ feeding ○ day-to-day care, such as nappy changing. 	<ul style="list-style-type: none"> • Are staff witnessed to be communicating appropriately to the baby's relatives? Is there a named nurse? • How are parents involved in care plans? [Ask parents if their baby has a care plan, were they involved in developing it, is it current, do they understand it?] • Are there any support groups available? Does the trust signpost carers to these groups if so? • Are bereaved families provided with information and support to make informed choices about their care which are right for them? Are they provided options and choices about how to make memories with their baby, if they wish to?
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<p>planning and making shared decisions about their care and treatment? Do people feel listened to, respected and have their views considered?</p> <ul style="list-style-type: none">• C2.6 Are people’s carers, advocates and representatives including family members and friends, identified, welcomed, and treated as important partners in the delivery of their care?• C3.3 How are people assured that information about them is treated confidentially in a way that complies with the Data Protection Act and that staff support people to make and review choices about sharing their information?		
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Responsive

By responsive, we mean that services meet people's needs

Key line of enquiry: R1 & R2

R1. How do people receive personalised care that is responsive to their needs?

R2. Do services take account of the particular needs and choices of different people?

Prompts	Professional standard	Tier 4 guidance
Report sub-heading: Service delivery to meet the needs of local people		
<ul style="list-style-type: none"> R1.1 Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? R1.2 Where people's needs and choices are not being met, is this identified and used to inform how services are improved and developed? R1.3 Are the facilities and premises appropriate for the services that are delivered? 		<ul style="list-style-type: none"> What engagement and involvement of families has there been in the design and running of the services? Is there a parents/carers panel? How does the service manage in busy times?
Report sub-heading: Meeting people's individual needs		
<ul style="list-style-type: none"> R1.4 How does the service identify and meet the information and communication needs of people with a disability or sensory loss. How 	<ul style="list-style-type: none"> DH Toolkit for Neonatal Services (2009) 	<ul style="list-style-type: none"> In areas where ethnic minority groups form a significant proportion of the

<p>does it record, highlight and share this information with others when required, and gain people's consent to do so?</p> <ul style="list-style-type: none"> • R2.1 How are services delivered, made accessible and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances? • R2.2 How are services delivered and coordinated to be accessible and responsive to people with complex needs?¹ • R2.3 How are people, supported during referral, transfer between services and discharge? • R2.4 Are reasonable adjustments made so that people with a disability can access and use services on an equal basis to others? • R2.5 Do key staff work across services to coordinate people's involvement with families and carers, particularly for those with multiple long-term conditions? • R2.9 How are services delivered and coordinated to ensure that people who may be approaching the end of life are identified, including those with a protected equality characteristic and people whose circumstances may make them vulnerable, and that this information is shared? 	<ul style="list-style-type: none"> • Accessible Information Standards 	<p>local population, are processes in place to aide translation?</p> <ul style="list-style-type: none"> • Does the provider comply with Accessible Information standards? <ul style="list-style-type: none"> ➤ Are there dedicated facilities available for parents and families of babies receiving neonatal care? Are these facilities in accordance with the DH Toolkit for High Quality Neonatal Services? For example: <ul style="list-style-type: none"> - Overnight accommodation, free of charge and with bathroom facilities <ul style="list-style-type: none"> ▪ One room per intensive care cot located within 10-15 mins walking distance of the unit ▪ Two rooms within or adjacent to the unit - Arrangements for the secure and readily accessible storage of parent's personal items - Cot-side non secure storage for personal items such as baby clothes - A parent sitting room
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¹. For example, people living with dementia or people with a learning disability or autism.

<ul style="list-style-type: none"> • R2.10 How are people who may be approaching the end of life supported to make informed choices about their care? Are people’s decisions documented and delivered through a personalised care plan and shared with others who may need to be informed? • R2.11 If any treatment is changed or withdrawn, what are the processes to ensure that this is managed openly and sensitively so that people have a comfortable and dignified death? 		<ul style="list-style-type: none"> - A kitchen with hot drink and snack making facilities, including a microwave - Toilet and washing area - Changing area for other young children - Play area for siblings of infants receiving care - Access to a phone and internet connection - A room set aside and furnished appropriately for counselling and to provide parents with privacy and quiet.
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Key line of enquiry: **R3**

R3. Can people access care and treatment in a timely way?

Prompts	Professional standard	Tier 4 guidance
Report sub-heading: Access and flow		
<ul style="list-style-type: none"> • R3.1 Do people have timely access to initial assessment, test results, diagnosis, or treatment? • R3.2 Can people access care and treatment at a time to suit them? 	<ul style="list-style-type: none"> • Standards for Hospitals Providing Neonatal Intensive and High Dependency Care (second edition, 2001) <ul style="list-style-type: none"> ○ Does the service meet the 70% cot occupancy guidance? 	<ul style="list-style-type: none"> • What is the admitting pathway to neonatal unit? • How long do babies wait for their operations? How is this monitored? Are babies prioritised on lists to be first?

- R3.3 What action is taken to minimise the length of time people have to wait for care, treatment, or advice?
- R3.4 Do people with the most urgent needs have their care and treatment prioritised?
- R3.5 Are appointment systems easy to use and do they support people to access appointments?
- R3.6 Are appointments care and treatment only cancelled or delayed when absolutely necessary? Are delays or cancellations explained to people, and are people supported to access care and treatment again as soon as possible?
- R3.7 Do services run on time, and are people kept informed about any disruption?
- R3.8 How is technology used to support timely access to care and treatment? Is the technology (including telephone systems and online/digital services) easy to use?

- Is there access to urgent / next day clinics?
- Is a paediatrician with appropriate neonatal training available in the hospital during times of peak activity, seven days a week
- Is every baby admitted to a neonatal unit with an acute medical problem seen by a consultant paediatrician with appropriate neonatal training within 14 hours of admission?
- GPs assessing or treating babies with unscheduled care needs have access to immediate telephone advice from an appropriate consultant.
- Each acute general children's service provides a consultant paediatrician-led rapid access service so that any child referred for this service can be seen within 24 hours of the referral being made.
- There is a link consultant paediatrician for each local GP practice or group of GP practices.
- Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.

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| | | <ul style="list-style-type: none">• Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week, for advice and support, with visits as required depending on the needs of the children using the service.• There is a link community children's nurse for each local GP practice or group of GP practices.• When a baby presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the baby's parents and carers.• Babies presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.• Healthcare professionals assessing or treating babies with unscheduled care needs in any setting have access to the baby's shared electronic healthcare record. |
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Key line of enquiry: **R4**

R4. How are people's concerns and complaints listened and responded to and used to improve the quality of care?

Prompts	Professional standard	Tier 4 guidance
Report sub-heading: Learning from complaints and concerns		
<ul style="list-style-type: none"> • R4.1 How well do people who use the service know how to make a complaint or raise concerns and how comfortable do they feel doing so in their own way? How are people encouraged to make a complaint, and how confident are they to speak up? • R4.2 How easy is it for people to use the system to make a complaint or raise concerns? Are people treated compassionately and given the help and support, through use of accessible information or protection measures if they need to make a complaint? • R4.3 How effectively are complaints handled, including to ensure openness and transparency, confidentially, regular updates for the complainant, a timely response and explanation of the outcome, and a formal record? • R4.4 How are people who raise concerns or complaints protected from discrimination, harassment or disadvantage? • R4.5 To what extent are concerns and complaints used as an opportunity to learn and drive improvement? 	<ul style="list-style-type: none"> • The NHS constitution gives people the right to <ul style="list-style-type: none"> ➤ Have complaints dealt with efficiently and be investigated. ➤ Know the outcome of the investigation. ➤ Take their complaint to an independent Parliamentary and Health Service Ombudsman. <p>Receive compensation if they have been harmed.</p> • The service provides children and young people with appropriate information in a variety of languages and formats including leaflets so they can make comments, compliments or complaints. Department of Health, You're welcome: Quality criteria for young people friendly health services, 2011 	<ul style="list-style-type: none"> • Is there clear evidence that in most cases people are supported? • Is there clear evidence that in most cases the complaint is managed appropriately and people are treated compassionately and supported? • Is there clear evidence that in most cases the complaint is investigated thoroughly? • Is there clear evidence that in most cases the complaint is formally recorded with accurate information? • How has the unit implemented the 'Friends and Family' for children in an accessible way?

Well-led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Key line of enquiry: **W1**

W1. Is there the leadership capacity and capability to deliver high-quality, sustainable care?

Prompts	Professional standard	Tier 4 guidance
Report sub-heading: Leadership		
<ul style="list-style-type: none">W1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?W1.2 Do leaders understand the challenges to quality and sustainability, and can they identify the actions needed to address them?W1.3 Are leaders visible and approachable?W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?	<ul style="list-style-type: none">Standards for Children's surgery – The Royal College of Surgeons, 2013NRLS - Being Open Communicating patient safety incidents with patients, their families and carers	<ul style="list-style-type: none">How is leadership organised on a shift by shift basis? Is there a nursing/ medical lead?Do all the consultants have job plans? Are these addressed yearly?

Key line of enquiry: **W2**

W2. Is there a clear vision and credible strategy to deliver high-quality sustainable care to people who use services, and robust plans to deliver?

Prompts	Professional standard	Tier 4 guidance
Report sub-heading: Vision and strategy		
<ul style="list-style-type: none"> • W2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities? • W2.2 Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care? • W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners? • W2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them? • W2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population? • W2.6 Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this? 		<ul style="list-style-type: none"> • Are staff aware of a departmental strategy? How integrated is it with the overall trust strategy? • Is it line with national recommendations / direction of travel for care for CYP?
Key line of enquiry: W3		
W3. Is there a culture of high-quality, sustainable care?		
Generic prompts	Professional Standard	Additional prompts
Report sub-heading: Culture		

<ul style="list-style-type: none"> • W3.1 Do staff feel supported, respected and valued? • W3.2 Is the culture centred on the needs and experience of people who use services? • W3.3 Do staff feel positive and proud to work in the organisation? • W3.4 Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority? • W3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised? • W3.6 Are there mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations? • W3.7 Is there a strong emphasis on the safety and well-being of staff? • W3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably? • W3.9 Are there cooperative, supportive and appreciative relationships among staff? Do 	<ul style="list-style-type: none"> • NMC Openness and honesty when things go wrong: the professional duty of candour • NRLS - Being Open Communicating patient safety incidents with patients, their families and carers • Duty of Candour – CQC guidance 	<ul style="list-style-type: none"> • Is there a focus on improving health outcomes embedded in the culture of these services? • What processes and procedures does the provider have in place to ensure they meet the duty of candour? For example, training, support for staff, policy and audits.
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staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?		
Key line of enquiry: W4		
W4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
Generic prompts	Professional Standard	Additional prompts
Report sub-heading: Governance		
<ul style="list-style-type: none"> W4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved? W4.2 Do all levels of governance and management function effectively and interact with each other appropriately? W4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for, and to whom? W4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care? 	<ul style="list-style-type: none"> NICE QS61 Statement 2: Organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. Intercollegiate Standards for care of CYP in emergency care settings (RCPCH 2012) covers staffing, training, facilities, communications and interfaces set out in a clear style and agreed by all professional colleges involved with urgent and emergency care A senior children's nurse is involved in the planning and development of children and young people's service provision and works in collaboration with local NHS children's services 	<ul style="list-style-type: none"> Is there an Executive or NED lead for the service? Who is responsible for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line? Is there a system in place to ensure that governance arrangements take account of and are aligned with recommendation published with national safety standards for invasive procedures? Is there effective trust board oversight of performance regarding antimicrobial prescribing and stewardship? What action is taken when issues are identified?

[Royal College of Nursing guidance on Defining staffing levels for children and young people's services](#)

Key line of enquiry: **W5**

W5. Are there clear and effective processes for managing risks, issues and performance?

Generic prompts

Professional Standard

Additional prompts

Report sub-heading: **Managing risks, issues and performance**

- W5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?
- W5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved?
- W5.3 Is there a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken?
- W5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?

- In all centres admitting children, one consultant should be appointed as lead consultant for paediatric anaesthesia. Typically they might undertake at least one paediatric list each week and will be responsible for co-ordinating and overseeing anaesthetic services for children, with particular reference to teaching and training, audit, equipment, guidelines, pain management, sedation and resuscitation. [Guidance on the provision of paediatric anaesthesia services 2016, RCoA](#)
- NICE QS 61: Organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance

- Is there evidence that winter management plans specifically include babies (e.g. to cover bronchiolitis season)?
- Is there evidence that summer management plans (especially trusts near the coast) address the needs of CYP?
- When did the board last receive a report on safeguarding children? What exposure does this service get at Board meetings?

<ul style="list-style-type: none"> W5.5 Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities? W5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care? 	<p>systems.</p> <p>http://www.nice.org.uk/guidance/qs61</p> <ul style="list-style-type: none"> 	
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Key line of enquiry: **W6**

W6. Is appropriate and accurate information being effectively processed, challenged and acted upon?

Generic prompts

Professional Standard

Additional prompts

Report sub-heading: **Managing information**

<ul style="list-style-type: none"> W6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance? W6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and do they challenge it appropriately? 	<ul style="list-style-type: none"> NICE QS121 Statement 5: Individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber, team, organisation and commissioner level. 	
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<ul style="list-style-type: none"> • W6.3 Are there clear and robust service performance measures, which are reported and monitored? • W6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? • W6.5 Are information technology systems used effectively to monitor and improve the quality of care? • W6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required? • W6.7 Are there robust arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches? 		
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Key line of enquiry: **W7**

Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

Generic prompts

Professional Standard

Additional prompts

Report sub-heading: **Public and staff engagement**

<ul style="list-style-type: none"> • W7.1 Are people’s views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups? • W7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups? • W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected characteristic? • W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs? • W7.5 Is there transparency and openness with all stakeholders about performance? 		<ul style="list-style-type: none"> • How does the service seek out and act on feedback from the families of babies? • Is feedback from the families of babies who use services reviewed by teams and the department and used to inform improvements and learning?
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Key line of enquiry: W8

W8. Are there robust systems and processes for learning, continuous improvement and innovation?

Prompts

Professional standard

Tier 4 guidance

Report sub-heading: **Innovation, improvement and sustainability**

<ul style="list-style-type: none"> • W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes? • W8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them? • W8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements? • W8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation? • W8.5 Are there systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work? 		
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