Southport and Ormskirk Hospital NHS Trust

Last rated
15 Nov' 2016

Children and Neonatal Services

You said	We listened	We did
There was an absence of a robust system to ensure that policies, procedures and guidelines were in date, referenced appropriately and reflected best practice		*All procedural documents have been thoroughly reviewed to ensure they are reflecting current best practice. A new process is in place to ensure that authors are provided with a sufficient notice period to allow for timely update, consultation and approval*
The Paediatric Emergency department should contribute to monthly mortality meetings instigated by the main Emergency department in relation to any child deaths.		*All child and neonatal deaths are fully investigated irrespective of Hospital site.* *In the event of a child death in the Adult A&E department, a Serious Incident investigation is undertaken by a multi-professional review panel including both a Consultant Pediatrician and Consultant in Emergency Medicine*
Mandatory and statutory training compliance was not meeting the Trust target of 90%		*Training compliance is actively monitored by the Matron and Clinical Director who directly target any areas or individuals showing non-compliance. This has resulted in month on month improvement in both nursing & medical staff compliance*
Dissemination of actions from complaints needed to be more robust, complaints were not being addressed in a timely manner and nor was there evidence of learning from complaints. Staff were not aware of the top three reasons why people complained about the service.		*Additional staff have received training in complaint handling which allows for a larger pool of investigators. This has resulted in more timely investigation and improved response times* *A monthly newsletter has been introduced so that all staff are aware of the themes and trends in the complaints received by the service and of any changes that have been introduced as a result.*
The Service did not have an Executive or Non-Executive lead which meant that the service was not represented at Board level		*The Executive Medical Director has been identified to represent Children's services at Board level.*
There should be closer working with other departments where children attend outpatient clinics to improve facilities and user experience		*Work is underway to relocate some of the clinics that children attend into the paediatric outpatient department. This has started with Ophthalmology and feedback received from children, parents and staff has been favourable. The environment within maxillo-facial unit has been improved to ensure it is more children friendly.*