Sheffield Children's NHS
NHS Foundation Trust

Western Bank
Sheffield
S10 2TH

www.sheffieldchildrens.nhs.uk

29 January 2024

Dear Ms Combes,

Kyra Aslam (Greaves)
Regulation 28

Further to the inquest of Kyra Ali Aslam which concluded on 6 July 2023. I write in response to the Regulation 28 Report to prevent future deaths issued on 5 December 2023 to Sheffield Children's NHS Foundation Trust. Under Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 you requested the Trust to consider your matters for concern and take action to prevent future deaths.

Kyra sadly died on 13 August 2022 at Sheffield Children's Hospital following a planned procedure to reverse a stoma.

I would like to assure you that the Trust takes the findings and the concerns very seriously and provides the following response to the concerns raised:

1. **Whether there is a culture which prevents medics from taking account of the views of parents or nursing staff when considering the overall presentation of patients.**

   The Trust has recognised that the views of parents and nursing staff have not always been listened to, through feedback we triangulate from inquests, serious incidents and complaints. As a result of this, we have undertaken a significant amount of work to consider and improve areas within our culture and the processes that underpin our ways of working. This includes:

   - Implementing new processes to ensure the clinical Care Groups are fully sighted on all complaints and Freedom to Speak Up themes including ones where families or colleagues feel unheard so that they can discuss and learn from these within their internal forums.
   - Implementation of 'Safety Wednesday' led by the Medical Director and Chief Nurse to review all incidents and complaints through the week. Areas of concern are escalated to Patient Safety Incident Triage Panel for further consideration and fed into the weekly Executive Team meeting on a Thursday to enable timely action.

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The learning from this process has already been rich and has specifically enabled me as Chief Executive (CEO) to speak to families before discharge, if appropriate.

- A new monthly Safety, Quality, Risk and Learning Committee provides a forum for organisation wide learning.
- Funding new Trust wide roles including Quality Matron; Patient Experience Leads and a sepsis Lead Nurse.
- Refresh of our Care Experience Group including stronger attendance, feedback and coproduction of action from The Trust's Youth Forum and Healthwatch.
- Implementing the new national Patient Safety Incident Response Framework with significant training and appointment of new Learning Response Learning Leads.
- Roll out of human factors training across the Trust.
- Thorough review of bereavement care following themes identified from incidents and complaints with input from families and the development of future proposals.
- Embedding the Trusts 'In it Together' culture framework within our People Plan and supporting this with leadership events and line management training.
- Scheduled Consultant engagement meetings for 2024, where feedback from specific learning can be shared with the Consultant body in the Trust.
- Development of the Team Leader role for doctors with a refreshed job role and review of time allocated for the role.
- Invitation of external groups to talk to Executive Team and Trust Board for example the Sheffield parent / carer forum came to present feedback from their engagement work Implementation of Patient and Carer Escalation

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Parent and Carer Escalation (PaCE)

The Trust has implemented a new process to enable parents and carers to escalate concerns about their child's clinical condition if they feel they are not being listened to. This new process is called PaCE (Parent and Carer Escalation). It is acknowledged by Sheffield Children's NHS FT that failure to recognise and treat patients whose condition is deteriorating is a cause of significant harm in healthcare environments. One resource in the early detection of deterioration is the contribution that patients and carers can make.

Understanding parental concern as an indicator of clinical deterioration and empowering them to speak up when they are worried is key in the context of improving care quality and safety particularly in terms of preventing avoidable harm in children. PaCE is a four-step process to encourage the concerned parent/ carer to initially speak with the nurse or doctor. If they are still worried they ask for the nurse in charge of the ward. If concerns continue they can ask to speak to the ward manager or the site manager and if they are still concerned following all these conversations they can call the number displayed on the poster to speak to the Senior Nurse on Call.

Posters are prominent in all inpatient areas. The new process was initially trialled on two wards. Following successful pilots this has been rolled out to all in-patient areas on the hospital site across the Trust from 3 November 2023. To date one call has been made to the Senior Nurse on Call and we will continue to promote and monitor use to ensure all patients and carers feel able to use this if needed. Further work we want to develop is around cultural competency of colleagues and ensuring any processes we have are inclusive and accessible.

The Trust has processes and policies in place for escalation by nurses should they feel that their concerns are not being heard, these policies are being updated and will be supported by training. The new Quality Matron post will play a significant part in enabling this culture change at ward level. All clinical colleagues also have access to the Freedom to Speak Up Guardian who will take concerns and raise these directly with the Executive Team.

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The Trust is committed to developing our leaders and teams so that everyone feels safe, are able to team up and to keep learning. Our Lead with Care framework supports this cultural approach and is something I personally champion as CEO. We have been very open within the Trust about our need to increase listening to our families and why we have put actions in place. As CEO I have reported back to our Trust Board on themes we are hearing and the actions in place. Whilst we have some areas of outstanding practice already, we are determined in our aim to have consistency across the Trust. We will be working hard to embed these actions to create the culture change everywhere for the safety and experience of all patients and families.

2. **Where a junior doctor is overruled by a Consultant, is that learning adequately explained to that junior doctor to learn for next time?**

   We believe that Sheffield Children's is a positive learning environment and this is evidenced in many areas by the GMC national trainee survey and by positive HEE quality assurance visits. We have however submitted an educational action plan to HEE to address areas where training is not at the level we expect, and our Director of Postgraduate Medical Education continues to review the quality and develop learning across all posts.

   We have invested in additional time for speciality clinical tutor posts which support the development of education locally for doctors in training and act as a local support for trainees to discuss their training and training needs. Any trainee placed at Sheffield Children's has a personal clinical supervisor assigned to them, their role is to provide learning through case-based discussions and review of their experiences (and address unmet learning needs or concerns).

   As a Trust we have introduced a new way for consultants to evidence their upskilling as a Clinical and Educational Supervisor. This is now linked to their appraisal process within their Scope of Work and gives very clear suggestions on how to meet the seven domains required by the GMC. We believe that this will maintain high standards amongst our trainers, increase their accountability and ensure they receive regular training to improve their approach to teaching and give them confidence to challenge colleagues who are not meeting the same standards. Acute medicine can at times require fast decision making by the most senior colleague present which can be appropriate in emergency situations, however embedding improved supervision training for all supervisors will work towards ensuring that all clinical contacts are viewed as learning opportunities.

   Additionally, trainees have access to the Freedom to Speak Up Guardian and the Guardian of Safe Working. Trainees are signposted to them as part of the induction process. The confidentiality of those speaking up is respected, in line with the Freedom to Speak Up Principles. Issues raised are brought to the attention of the Executive Medical Director/Deputy Medical Director who review the issues raised and if appropriate discuss with the individual(s). We also have a very active junior doctor forum which encourages trainees to share concerns that they have about training posts within the Trust.

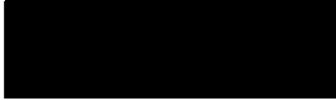
The continued work we are doing with our Quality Strategy, known as the Quality Promise, which has just been launched across the Trust, will assist in embedding our culture to provide safe, kind and outstanding care to everyone. In implementing human factors, engagement with leaders and everyone across the Trust highlighting the importance of listening to parents/ carers and other colleagues across the Trust, along with the learning culture that is being implemented through PSIRF (Patient Safety Incident Response Framework).

The Trust's 'In this Together' culture and behaviour framework, Lead with Care approach and the Education and Learning Strategy that have been rolled out across the Trust will ensure that our culture develops and that learning is embedded across all areas including surgery.

As the CEO of Sheffield Children's the culture of our Trust is of huge importance to me. I have personally triangulated and fed back themes that have been raised and identified to our Board and I am ensuring that we continue to develop and embed our culture through further projects including our bereavement care and sepsis work.

I trust that this provides adequate assurance on the matters of concern. Please do not hesitate to contact me if you require anything further.

Yours Sincerely,



Chief Executive