East Kent Hospitals University NHS Foundation Trust

Queen Elizabeth The Queen Mother Hospital

Inspection report

St Peter's Road
Margate
CT9 4AN
Tel: 01227766877
www.ekhuft.nhs.uk

Date of inspection visit: 29 July 2021
Date of publication: 15/10/2021

Ratings

Overall rating for this service

Requires Improvement

Our findings

Overall summary of services at Queen Elizabeth The Queen Mother Hospital

Requires Improvement 

We carried out this unannounced focused inspection because at our last inspection we rated the service overall as inadequate and we received information giving us concerns about the safety and quality of the services. We focused our inspection on the key questions that were rate inadequate at our last inspection. We also looked at those parts of the service that did not meet legal requirements at the time of the last inspection.

Queen Elizabeth The Queen Mother Hospital provides; medical care (including older people's care), services for children and young people, critical care, end of life care, outpatients and diagnostic imaging, surgery, and urgent and emergency services.

We did not rerate the hospital at this inspection. The previous rating of requires improvement remains. See the children and young people section for what we found.

During the inspection, we visited Rainbow ward, the special care baby unit, theatres, recovery, radiology, fracture clinic, and the children's outpatient department at Queen Elizabeth The Queen Mother Hospital. We spoke with five parents, two children and 29 staff including; nurses, doctors, managers, allied health professionals and support staff. During our inspection, we looked at six sets of patient records.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Services for children and young people

Requires Improvement  

We rated this service as requires improvement. Our rating of this service improved because:

- The service had enough staff to care for children and young people and keep them safe.
- Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well.
- The service controlled infection risk well.
- Staff assessed risks to children and young people, acted on them and kept good care records.
- They managed medicines well.
- The service managed safety incidents well and learned lessons from them.
- Staff collected safety information and used it to improve the service.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued.
- They were focused on the needs of children and young people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

However:

- There were two key questions rated requires improvement at the last inspection. We did not fully inspect these key questions which meant we could not rerate these.
- Training compliance for medical staff was worse than the trust target of 85%. Medical staff did not meet the trust target in ten of the 11 modules they were required to complete.
- Not all incidents were investigated and closed in a timely manner.
- Not all staff were following the trust policy for pre-operative fasting resulting in patients fasting longer than planned.
- Not all staff were aware of the service's draft vision.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff completed it.

Services for children and young people

Nursing received and kept up-to-date with their mandatory training. However, not all medical staff had kept up to date with their mandatory training. Staff had to complete nine statutory training modules and five mandatory training modules.

Nursing staff compliance for the statutory modules was; 98% for fire safety, 99% for health and safety, 98% for information governance, 99% for equality and diversity, 100% for infection prevention and control level one, 90% for infection prevention and control level two, 99% for moving and handling, 100% for safeguarding children and young people level 2, and 99% for safeguarding and young people level 3. All the statutory modules met the trust target of 85%.

Nursing staff compliance for mandatory training modules was; 100% for safeguarding adults level 1, 99% for safeguarding adults level 2, 83% for hand hygiene, 88% for hospital life support, and 79% for paediatric hospital life support. All but two mandatory modules met the trust target of 85%.

Medical staff compliance for the statutory modules was; 68% for fire safety, 84% for health and safety, 71% for information governance, 81% for equality and diversity, 61% for infection prevention and control level two, 74% for moving and handling, 100% for safeguarding children and young people level 2, and 64% for safeguarding and young people level 3. One the statutory modules met the trust target of 85% with seven not meeting their target.

Medical staff compliance for mandatory training modules was; 74% for safeguarding adults level 2, 63% for hand hygiene, 73% for national life support, and 60% for paediatric hospital life support. None of the four mandatory modules met the trust target of 85%.

Not all staff had completed the resuscitation training. Managers told us this was due to the pandemic which had resulted in a reduction in face to face training. Staff told us they felt well supported while this training had been delayed for some staff. Staff received additional resuscitation training during this time which included; simulation training, online learning and informal training provided on the wards.

Mandatory training was comprehensive and met the needs of children, young people and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust set a target of 85% completion for mandatory training. Mandatory training compliance for administrative staff was better than the target at 100% overall for all eight modules they were require to complete. Nursing staff met the target for 11 out of 14 modules. However medical staff did not meet the trust target in ten of the 11 modules they were required to complete.

Managers told us during the peaks of the pandemic staff had needed to focus on face to face patient care. This had resulted in mandatory training compliance falling however, they had a plan to improve compliance and felt their compliance level was good in light of the last 12 months of activity during the pandemic.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. This included increasing staff awareness of mental health conditions with three training modules. One of these modules was developed with service users and was partly delivered by adults that had experience of using mental health services as a child.

Services for children and young people

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Data showed that 100% of staff had received safeguarding children and young people level 2 training, while 89% had received level 3 training. This was in line with the standards set out in the intercollegiate document for healthcare staff providing care to children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with had a good understanding of who the named safeguarding lead for the trust was and they described how they would raise concerns. For example, one member of staff told us of a referral to the safeguarding team because of suspected abuse. Information on safeguarding was visible throughout the department for staff, patients and visitors to see. This included the details of who to contact to raise concerns.

Staff told us that safeguarding concerns and actions taken were recorded in patient notes as per the safeguarding policy. The service's electronic record system notified staff of children with a safeguarding alert against their record. Staff showed us how this was flagged and what action they would take depending on the situation. For example, the outreach team told us about when the system had flagged a domestic violence alert on a child's record. The record showed that the local authority was aware of the concern and to protect staff carrying out home visits, arrangements were made to ensure staff visited the child and parent in pairs.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

The hospital had an up to date infection control policy which was in line with Public Health England's Covid-19: infection prevention control guidance (2020). There were systems for testing and screening children and young people for Covid-19 on admission through various pathways. Children's service had defined Covid-19 negative and positive areas to prevent the spread of infection and we saw patients susceptible to infection were cared for in side rooms.

All areas we visited were visibly clean, tidy and free from dust. There were suitable furnishings which were clean and well-maintained. The trust employed housekeeping staff who were responsible for keeping areas clean and the frequency of cleaning had increased in response to Covid-19. Patients told us they thought the areas they had visited were cleaned to a high standard and they had seen cleaners, cleaning throughout the day. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Disposable curtains used in patient areas, were clean and labelled to show dates of their last change. Curtains were routinely changed every three months and were also changed before this if they were visibly dirty or the area had had an amber clean. An amber clean was required after use by patients such as those with Methicillin-resistant Staphylococcus aureus (MRSA), Group A Streptococcal infection and chickenpox.

The service generally performed well for cleanliness. The children's wards displayed up to date results of infection control audits including, hand hygiene and ward cleanliness on the information boards for all staff and visitors to see.

Services for children and young people

Staff we saw on the special care baby unit and Rainbow ward followed appropriate hand hygiene techniques. In June 2021, Rainbow ward achieved a compliance rate of 93% in the hand hygiene audit, 97.9% for bare below the elbows, 98% for ward cleanliness and 100% for commodes. The special care baby unit in June 2021 achieved compliance of 98% for the hand hygiene audit and 99% for bare below the elbows.

There were enough handwashing facilities in all areas and alcohol hand rub available at the entrance and within bed spaces. Personal protective equipment such as gloves, aprons and face masks were readily available in enough quantities for staff to use.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw communal toys in the playroom were cleaned after each patient session. Outside of the play sessions, staff gave children and young people individual packs with age appropriate activities and toys which they took home to reduce the risk of cross infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Rainbow ward had 20 beds in total, with two side rooms used for isolation, a children's assessment unit with two beds and one baby bed. The special care baby unit had 14 cots and two high dependency cots.

Entrances to the children's ward and the special care baby unit were kept locked and accessible to ward staff only by key fob and a buzzer system for visitors. Entrance doors had a CCTV system, allowing staff to see who was at the entrance before buzzing them in or out. This meant that there was less risk of children absconding or child abduction.

Staff carried out safety checks of specialist equipment. Resuscitation equipment was

available on trolleys in theatres, day surgery, Rainbow ward and the special care baby unit. We saw equipment for different age groups was available. Daily checks were completed, and tamper proof tags were used to show if the contents had been accessed. Full internal checks of the trolleys were completed weekly. We checked four trolleys and found that checks had been completed in line with trust policy.

The service had enough suitable equipment to help them to safely care for children and young people. We checked a range of consumable items including, syringes and dressings. We found all items were within their expiry date and staff confirmed there was a process to ensure that stock approaching its expiry date was used first or rotated out and replaced.

Staff disposed of clinical waste safely. We saw different coloured waste bags, labelled bins and sharp bins for different types of waste, such as general waste and clinical waste for swabs and dressings.

There were accessible toilets for people with mobility difficulties and nappy changing facilities for parents with children within the department.

Services for children and young people

Staff undertook fire safety training. All fire exits were clearly marked, and fire alarms were regularly checked. Evacuation plans were clearly displayed and included evacuation routes. However, we found three fire extinguishers in the special care baby unit that were a month out of date. We informed the ward manager of our findings. After our inspection, the trust told us the out of date fire extinguishers were replaced. The trust carried out various reviews and risk assessments to ensure there were no other fire safety issues.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used the paediatric early warning system (PEWS) to identify children or young people at risk of deterioration and escalated them appropriately. PEWS is a nationally standardised assessment of illness severity and determines the need for escalation based on a range of patient observations. Staff used handheld electronic devices to record patients' PEWS scores. When scores indicated a deteriorating patient, the nurse was prompted to follow an escalation pathway. Staff told us they regularly participated in simulation training to reinforce learning and embed safe PEWS practices.

Nursing staff sought medical input when the PEWS score indicated sepsis (a severe blood infection). The service undertook a monthly audit of their compliance with the trust's sepsis policy. This audit included compliance with the use of the trust's sepsis screening tool which showed compliance on the children's ward of 78% for April 2021, 100% for May 2021, and 79% for June 2021. They also looked at compliance of staff administering the first dose of antibiotic to children with sepsis within one hour which showed compliance on the children's ward of 100% for April, 50% for May and 0% June 2021. For May and June, the noncompliance represented two patients and the audits recorded that these patients had a documented reason for why their antibiotics were not given within an hour. Each audit had an action plan to address any noncompliance. For example, the June 2021 audit recommended that supervision of student nurses and healthcare workers should be prioritised and for staff to address escalation expectations for this group of staff. To review the effectiveness of this action, the service planned to review compliance in the July audit to see if there was an improvement for children whose abnormal observations or sepsis risk had been completed by student nurses or healthcare workers.

Staff completed risk assessments for each child and young person on admission and reviewed this regularly, including after any incident. Nursing staff on Rainbow ward identified patients who required one to one or two to one care. However, nursing staff told us that as there was not always enough staff available to do this, as a result they prioritised these patients as necessary to ensure risks were mitigated. On the day of our inspection, we saw a healthcare worker providing one to one care throughout our inspection which was in line with the patient's care plan.

Staff on Rainbow ward were not trained in restraint but had received training in de-escalation skills. Staff called hospital security to assist with restraint when other less restrictive options were not effective. Security staff told us they undertook a four-day course with one day dedicated to carrying out physical interventions. This training was updated every three years. Nursing staff told us during physical intervention they would monitor how security were handling the situation and gave instructions to security staff in order to diffuse the situation. All restraint incidents were documented and reported.

The service had access to the local child and adolescent mental health service which enabled children who were experiencing acute mental health problems to receive appropriate and timely care.

We saw information about the availability of chaperones displayed in the children's ward. Staff told us that they were able to provide a chaperone when it was required.

Services for children and young people

Nurse staffing

The service worked collaboratively to ensure they had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service was staffed by qualified children's nurses.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance and adjusted staffing levels according to the needs of children and young people. However, some staff felt the staffing levels did not always reflect the needs of the department.

Data showed the number of nurses and healthcare assistants did not always match the planned numbers. The staffing rotas we saw included days that did not have the planned number of nursing staff, but these numbers still met the national standards for safe staffing. The service monitored their staffing levels against their planned level and the national standards. Leaders used this information to review the number of staff they needed to provide safe care and produce business cases for additional recruitment.

On the day of our inspection, Rainbow ward's staffing level were as planned. The day shift was staffed by five registered children's nurses and one healthcare support worker. The night shift had four registered children's nurses and one healthcare support worker.

The service had a clear way of assessing staffing requirements and escalating risks such as staffing particularly when there were complex patients needing one to one monitoring. Staff highlighted staffing and capacity issues at the 8.30am safety huddle and escalated to members of the care group who in turn informed the head of nursing.

Where there were unforeseen staff shortages, the ward manager told us they re-assessed staff rotas and contacted staff at the William Harvey Hospital for assistance. Staff told us they were flexible and were willing to cover shortages at the other site when needed.

The department had a paediatric senior nurse on-call service. The service was provided Monday to Friday during the hours of 5pm to 8am and all day on the weekends and bank holidays. The on-call senior paediatric nurse was available to assist staff with escalating staffing concerns, bed management and provided support and clinical expertise in relation to clinical paediatric care outside of normal working hours.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff said when they needed extra staff bank staff were preferred with these being the staff that already worked in the children's service. Staff and managers told us they did not often use agency staff but when needed agency staff, these would be regular agency staff that were familiar with the service.

The children's ward was supported by a range of specialist nurses covering diabetes, cystic fibrosis, oncology, respiratory and epilepsy. There was also one registered play specialist who was supported by a healthcare assistant.

The service's vacancy rate was higher than the trust target of 9%. The service had 12% vacant nursing posts, however this included seven whole time equivalent nursing posts that had recently been created through a business case to expand their workforce.

Services for children and young people

There were no vacancies in the special care baby unit.

The service's sickness rates were slightly higher than the trust target of 5%. The average sickness rate for nursing staff over the past 12 months was 6%.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The children's department had eight consultants in post and was in the process of recruiting a nineth consultant. Nursing staff told us they felt well supported and there was always a doctor available when needed.

Overall, the medical staff matched the planned number and we saw this on the day of the inspection. The day shift was staffed by one consultant, two specialist doctors and four foundation year doctors. The night shift was staffed with one consultant, two specialist doctors and one foundation year doctor. This provided a good skill mix of medical staff on each shift and was reviewed regularly.

Medical shift patterns saw one consultant covering 8.30am to 5pm day shift and a second consultant covering the late shift from 2.30pm to 9pm. The late shift consultant was also responsible for on call cover between 9pm and 8.30am. A third consultant covering acute care was available from 2pm to 8pm.

The service had 11 middle grade doctors. The day shift was supported by two specialist doctors covering general paediatrics working 9am to 9pm and a second from 8.30am to 9pm. A third specialist doctor supported the neonatal service from 8.30am to 5pm. The night shift had two specialist doctors, one covering the children's assessment unit and the emergency department and another covering the special care baby unit and Rainbow ward. At the weekend, there were eight whole time equivalent doctors available on site.

In March 2021, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of foundation year 1-2 staff was also lower. However, the trust had more middle grade doctors than the England average. Medical staffing had improved since our last inspection and the service had put in a business case aiming to increase the number of consultants to 14 by 2022/3.

The service had a high vacancy rate for medical staff at 23%, however this included six new consultant posts created by a business case to expand their medical staffing which had not been recruited to yet. Without these posts the service had a vacancy rate of 8%.

Sickness rates for medical staff were low. Medical staff for the service had an average sickness rate of 2.8% for the past 12 months.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Services for children and young people

All staff could access patient notes easily. The service used both paper and electronic records with the aim to transition to a paperless records system in the near future. Paper records were stored securely in locked trollies next to the nurses' station. Each member of staff had individual log in details to access electronic records. All nursing and medical staff had received training in using the electronic system. Most staff we spoke with felt confident using the electronic system but told us they just needed to get used to it.

Patient notes were comprehensive. We reviewed seven patient records. Records we reviewed were completed appropriately. For example, all records contained details of patients' presenting conditions, their medical history and current medication. Records were signed and dated by the clinician making the notes and diagnoses and management plans were documented. Nutritional status was consistently recorded, as well as family discussions and patient observations.

The service carried out monthly audits reviewing nursing documentation and performed well in the audit. The average compliance rate for the last 12 months was 87%.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Room and medicine fridge temperatures were monitored daily and were in range during our inspection. Staff we spoke with understood the importance of storing medicines at the recommended temperatures and the escalation process if temperatures were out of the desired range.

All medicines we checked were within their expiry dates. Oxygen cylinders were full and within their expiry date.

Staff followed current national practice to check children and young people had the correct medicines. We reviewed seven prescription charts and saw medicines were administered correctly and in a timely manner. We saw nurses checking the name, date of birth and any allergies and the prescription charts to confirm the right medicines were given to the correct child or young person.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. There were appropriate, secure, storage facilities for medicines, with a dedicated medicines storage room in each area. Medicines storage rooms were secured by keypad access and all medicines cabinets, trolleys and fridges were locked. The service used FP10 prescription pads (a type of prescription that can be used at any pharmacy). FP10s were locked and recorded on a log when used, which was in line with best practice and legislation. The lead registered children's nurse on shift held the key for the clinic's medicines cupboard, which was in line with guidance.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. The pharmacy team visited the children's ward daily and were available to provide specific advice to children, young people and their families about their medicines. The team was responsible for restocking medicines every week.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However,

the service did not investigate incidents in a timely manner. However, the service did not investigate incidents in a timely manner. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The trust had an electronic reporting system to record safety incidents and near misses. Incidents were graded according to the severity and impact on the individual or the service.

Staff knew what incidents to report and how to report them.All staff were familiar with the reporting system and the incident reporting policies. Staff had a clear understanding of their responsibilities to report incidents in order to maintain safety within the service.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us that the culture around reporting of incidents had improved. Managers encouraged and supported staff when reporting any incidents. Staff said they received feedback on the incidents they had reported through staff meetings, safety huddles and newsletters.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Staff were aware of their duty to be open with patients and families when things went wrong. All incidents we looked at had duty of candour considered and carried out when needed.

The service had zero never events from July 2020 to June 2021. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported one serious incidents (SIs) which met the reporting criteria set by NHS England from July 2020 to June 2021. This was related to a healthcare associated infection or infection control incident.

Children and young people service at East Kent University Hospitals reported 1,351 at both Queen Elizabeth The Queen Mother Hospital and William Harvey Hospital from June 2020 to July 2021.

The most common types of incidents reported were, delay or failure, care or treatment and medication.

Most incidents were classified as no harm (1038 or 77%), 298 (22%) low harm, 13 moderate (1%) one severe (0%) and one incident reported as a death (0%). The high proportion of no and low harm incidents demonstrated a good incident reporting culture.

Incidents were not always investigated in a timely way. Data shared by the trust showed that many incidents were open for more than six weeks, which was not in line with the trust's policy. An average of 80 incidents each month from August 2020 to June 2021 were reported as breached. This meant the service did not learn from the incidents or act quickly enough to prevent the incidents from happening again.

Services for children and young people

The service was aware of the number of delayed incident investigations. Leaders had recruited an additional band 7 nurse to support the governance team with incident investigation. They had also recruited a band 3 support worker to help coordinate responses to incidents. The service was also being supported by the local commissioning group to improve their incident investigation program.

Is the service effective?

Inspected but not rated

We did not inspect the full key question of 'Is the service effective?', however we did follow up on the following areas we told the trust to improve from our last inspection.

We told the trust they must ensure that the needs of children and young people presenting in mental health crisis are considered and met.

Staff considered and met the needs of children and young people presenting in mental health crisis. Agency staff with experience of caring for children in mental health crisis were booked to support the patients which was often a registered mental health nurse. Ward staff had completed training to give them an awareness of mental health conditions and how best to support these children.

The service was working to improve the care provided to children and young people presenting in mental health crisis. Managers had seen a rise in the number of children in mental health crisis staying in the trust for longer periods. Managers told us this was as a result of insufficient capacity in the children's mental health services. The service had plans to adapt one of their side rooms on the ward to be tailored to meet the needs of children presenting in mental health crisis and waiting for a bed in the mental health services.

We told the trust they must review their policy and practice on pre-operative fasting for children to ensure it is aligned to the national guidance.

The service had an up to date policy on pre-operative fasting which was in line with national guidance. Staff told us this policy had been adopted by most staff but not all staff had changed their practice yet. Staff told us they challenged noncompliance with the policy and staff were receptive to learning about the new policy. Patients were given intravenous fluids in line with this policy when fasting before surgery.

During our inspection we spoke to a young person who expressed to us that they were hungry. Staff had explained that there was a delay with their surgery, and this had extended their fasting session longer than what was expected.

Is the service responsive?

Inspected but not rated

We did not inspect the full key question of 'Is the service responsive?' however we did follow up on the following areas we told the trust to improve from our last inspection.

Services for children and young people

We told the trust they must ensure the views of children and young people are taken into consideration to aid service provision and make sure the care and treatment meets their needs and reflects their preferences.

The service had taken the views of children and young people into consideration to aid service provision and make their care and treatment meet their needs. We spoke to patients and families that told us the care had been provided in a way that reflected their child's preferences. The service had started a needle phobia group to support diabetic children with a fear of needles. Parents had told the neonatal service they felt a sharp change in support provided on the point of discharge from the hospital. The hospital had responded to this feedback and trialled an outreach service to provide care and support at home to help the transition to community services. They received positive feedback about this service so have continued this trial and have made a business case to make the outreach service permanent.

We told the trust they should ensure that the pathway for providing care when a child dies is known and understood by all staff likely to be affected.

Staff knew how to follow the trusts pathway for providing care when a child died. All staff we spoke to were aware of how to access the pathway which was contained within a dedicated box. They also knew how to get support from the palliative care team.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had a clear leadership structure for their children's and young people's care group. This was led by a triumvirate dedicated to children's health services which had a lead for; nursing, operations, and medical staff. Staff felt well supported by these leaders. Leaders and staff told us they felt since having a dedicated care group for children's health the trust had become more aware of the needs of children.

The children's health care group was represented at the trust board. The executive lead for the care group was the chief nurse and there was also a non-executive lead for the care group. Local leaders said the board was aware of the needs of children in the trust. Concerns about individual children including those experiencing mental health crisis were escalated to board members. The executive team were aware of these children and advocated for their needs including escalating the need for suitable mental health treatment facilities when there were delays caused by a lack of service provision.

Leaders understood the challenges the department faced and led improvements. Staff spoke highly of their leadership at all levels and described them as approachable, knowledgeable and supportive.

Services for children and young people

Leaders supported staff to develop their skills and take on more senior roles. Staff and leaders told us about opportunities for additional training offered to staff. Leaders made business cases to expand these opportunities for staff.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action. The children's and young people's service had been developing their own vision however, this had not been completed. The service had engaged with all relevant stakeholders in their development process.

The trusts vision was "great healthcare from great people" and staff knew about this vision. The trust also had a mission statement to "improve health and wellbeing". We saw many examples of staff improving healthcare. This included participating in clinical research programs.

The children's and young people's care group had a draft vision. Leaders told us the service had held focus groups with staff, parents and children to gain each of their views on how the service should be developed in the future. Children and parents told us they felt care was provided in a way tailored to their needs. Staff knew about the work being carried out to create a vision for the care group however, the draft vision had not been shared with them at the time of our inspection.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt proud of the work they did and described a positive team approach within the department and with colleagues at William Harvey Hospital. There was a good working relationship with the community staff which helped facilitate early discharges. We saw colleagues working collaboratively together and managers supporting staff to ensure their wellbeing and the smooth running of the service.

We asked staff if or how they would raise issues about safety concerns or poor practice in their department. They felt confident about taking any concerns to their line manager and felt they would be listened to and the issue dealt with.

Most patients and/or parents we spoke to knew how to make a formal complaint if they needed too. The service used an engaging feedback wall called "Best on vests, rants on pants" to receive immediate feedback from children and young people. Staff encouraged children and young people to give feedback this way so they could resolve the issue quickly.

The 2020 NHS staff survey for the children's health care group showed a score of 7.8 for safe environment in relation to bullying and harassment which was better than the trust average of 7.3. In the survey, 10 is a perfect score and 0 is the worst with 8.1 being the average across the country.

The service promoted equality and diversity in daily work and provided opportunities for career development. The 2020 NHS staff survey for the children's health care group showed a score of 9.1 for the service's approach to equality, diversity and inclusion which was better than the trust average of 8.8.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Services for children and young people

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had monthly governance meetings where performance information was reviewed, and actions identified to improve the service. Leaders of the service participated and submitted data to board subcommittees which then raised escalated to the board. Information and decisions were disseminated from board or the subcommittee to patient facing staff. Staff told us they were kept up to date with the service's performance via team meetings, newsletters, staff notice boards, and email updates. The service also shared their successes and escalated information via this structure to allow the board to know about the positive work being done by staff and any concerns they had about the service.

The service had a weekly message to update all staff on key changes and important reminders which were read out at every handover that week. These included a reminder on the use of pain scores and actions to be taken when a child or young person is in a lot of pain.

The trust monitored their performance against other trusts using national audits. The service had submitted data to the paediatric diabetes audit, national neonatal audit program, CQC Children and Young People's Survey however, some audit programmes had not been run in the past 12 months due to the pandemic.

The service held meetings to monitor and focus improvement on safeguarding children and young people across the service. Leaders attended meetings every two months which included discussion of their; safeguarding audit plan, safeguarding action plan, safeguarding activity, serious case reviews, and additional safeguarding training to improve compliance.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff knew what they were responsible for and where to raise concerns. Staff told us they reported their concerns, these were listened to, and action was taken to address them. The chief medical officer held a monthly meeting to review concerns and risks from all staff. This provided staff of all grades another route to raise concerns to senior leaders. Concerns were escalated from either the monthly risk meeting or via the governance meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had effective systems for identifying risks and planning to eliminate or reduce them. We saw that the risk register was comprehensive, and the service used control measures to lessen risks wherever possible

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service held monthly risk meetings to review risks on their risk register and to assess new risks. The service had identified 25 risks to the service such as nursing staff failing to recognise children and young people that present with mental health issues or learning disabilities and difficulty recruiting foundation year doctors with adequate neonatal training. The risk register identified the current level of risk, the risk score associated with it and progress notes for each risk.

At the time of our inspection, service leaders were planning for the winter to ensure the service was prepared for a surge in flu, COVID-19 or respiratory syncytial virus (a virus that causes bronchiolitis) admissions common during the winter months. This was to ensure the service could manage an influx of patients admitted.

The service had a major incident plan which was next due for a review in September 2022. The plan detailed how the trust would respond to any major incident and had defined roles and responsibilities for staff in the event of a major incident. The plan had a section dedicated to incidents involving children. We asked seven staff about major incident plans and all knew how to access information on these plans.

There were other plans for responding to severe weather and a business continuity plan. All were in date, included contact information for local networks such as other hospitals and organisations in the region.

The service participated in several audits to measure the quality of provision of patient care, these included local audits for hand hygiene, record keeping and medication.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via both paper and electronic patient records and the staff intranet.

The information systems were integrated and secure. Paper records were kept in locked trollies. Electronic records and digital information were kept on computers that were secured with usernames and passwords for each member of staff.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff assessed the computer systems quickly with their smart cards along with a passcode. This logged them into all systems they needed to use. The cards had the staff members photo to identify each card to its owner. We saw staff removed their smart cards when they had finished using computers preventing unauthorised access to information. Staff told us that most systems worked well to quickly display the information they needed. However, the digital system used by the trust to monitor observations was sometimes slow to input new sets of observations.

All staff had access to policies, procedures and other key information through the trust intranet. This contained information on mandatory training, professional development, and staff support. The trust also used the intranet to provide reminders of patient safety initiatives and how to access specialist support in the hospital.

Locally, leaders had access to a range of performance measures about quality, operations and finances, and used it to improve the service. They regularly collated information and fed this back to the board and circulated it amongst staff throughout the trust.

The service collected reliable data and analysed it. The service had an audit program to collect data and used this to provide assurance and focus improvement work. They had used data to model the potential increase in children needing inpatient care due to a surge in respiratory illness this winter. Leaders used this information to plan what staffing and equipment they would need to safely care for these children.

Data shared by the trusted showed that 91% of all staff had completed information governance training.

Services for children and young people

The service submitted data to national audit programmes to support improvements in their own service and those across the country. This included the National Neonatal Audit Programme which in the 2018 report showed the hospital was within the expected range in comparison to other hospitals for three audit measures and was better than expected for one audit measure. However, in the past year several audits were suspended due to the global pandemic.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff we spoke to felt engagement with leaders was good and had significantly improved in the last couple of years. They told us suggestions for service developments were listened to and acted upon by leaders.

Nursing staff told us that they attended regular staff meetings. The meetings held shared information and learning. We reviewed minutes from meetings held from April 2021 to June 2021. These staff meetings enabled staff from children and young people's services to discuss issues of importance or raise areas of concern. Staff shared ideas, opinions and feedback. If staff did not attend the meeting, they received feedback at staff handover, minutes on the staff board and by email.

Managers told us communication with child and adolescent mental health services (CAMHS) and eating disorder services had improved. The matron met with the CAHAMS manager monthly and staff had weekly meetings with CAHAMS services. Staff were encouraged to dial into the cross-sector meetings to gain insight or ask for advice for caring for children in crisis as children and young people could be on the ward for up to two months waiting for a bed in a tier 4 service. Tier 4 in patient services provide specialised assessments and treatments for children and young people with emotional, behavioural or mental health difficulties.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service used information to improve care. The service had carried out an improvement plan since our last visit in 2018 with multiple success to improve care and continued to work on improvements. One improvement made by the service was a service for parents while not present to see their babies in the special care baby unit. This service with consent from the parents would have nurse send pictures of videos of their baby to them to provide parents with updates. Parents told us they valued and appreciated this service improvement.

From November 2020, the children and young people care group had been piloting an outreach service. Staff in the outreach team supported the department with reviewing babies and initiating discharge therefore enabling staff to discharge neonatal patients earlier with a plan to provide support in the community. The outreach team visited discharged patients at their home within a week of their discharge and additional appointments were booked as necessary. During the home visits, the outreach team supported babies to transition from bottle to breast feeding, gave parents basic life support training and taught them other forms of basic care such as safely sterilising milk bottles and carrying out observations on their babies. Staff gave us examples of when they had identified patients that needed additional support and were referred to the hospital or other organisations depending on the concern. We saw positive feedback from other health professionals including health visitors, GPs and parents. A business case to make this service substantive had been put in as a result of its success.

Services for children and young people

Staff had completed research including to add to the knowledge base on vaccination of babies born before their due date. Staff were supporting ongoing research projects including one looking at the feeding regime for babies born early.

Outstanding practice

We found the following outstanding practice:

- The service had a children's needle phobia group to support children with diabetes.
- The service had a training module to help staff understand the needs of children with mental health conditions and learning disabilities. This was partly delivered by adults that had experience of being a child with mental health needs and learning disabilities.

Areas for improvement

Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

- The trust should improve the timeliness of investigations and close incidents in a timely way.
- The trust should take steps to improve mandatory training compliance rates for medical staff.
- The trust should ensure all staff follow trust policy relating to pre-operative fasting.
- The trust should ensure that they have a vision for children and young people's services and a strategy based on this to develop a service that meets the need of their community.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a specialist advisor with an interest in children and young people services. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.