Rotherham General Hospital

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Ratings

Overall rating for this hospital

Are services safe?	
Are services well-led?	

Summary of findings

Overall summary of services at Rotherham General Hospital

The Rotherham NHS Foundation Trust was awarded foundation status in 2005 and provides a wide range of acute and community health services to the people of Rotherham (population approximately 261,000). The trust provides the full range of services expected of a district general hospital including urgent and emergency care, maternity, paediatrics, surgery, medicine, critical care and community services for both children and adults.

Previous reports relating to this trust can be found here: https://www.cqc.org.uk/provider/RFR

We carried out a focused inspection at Rotherham General Hospital on 7- 10 July 2020 to review the processes, procedures and practices for safeguarding children and young people. We looked at parts of the safe and well-led domains.

We did not rate services because this was a focused, short notice inspection in response to specific areas of concern. We inspected safeguarding processes in urgent and emergency care, the children's ward and children's assessment unit, maternity services and community services for children and young people. We also looked at the wider oversight and management of safeguarding children and young people across the trust.

Following our inspection, we put our concerns formally in writing to the trust and asked that urgent actions be put in place to mitigate the risks to children and young people.

The trust provided a detailed response including improvement actions already taken or planned, and all actions were due for completion by November 2020. This provided assurance that sufficient action had been taken to mitigate any immediate risks to patient safety. We will continue to monitor this information through our routine engagement with the trust.

We found:

- Case records we reviewed showed there were missed opportunities to safeguard children and young people.
- Staff understood their responsibilities for safeguarding children and young people. However, the trust's safeguarding children processes, procedures and practices did not adequately support the identification and protection of children and young people who may be at risk of harm.
- Four different recording systems were in use across the trust to capture children and young people's information. Gaps between systems, and a reliance on staff to remember to check all the systems to build up a full picture of care, meant that sometimes information was missed or not shared with everyone, and children and young people were exposed to the risk of harm.
- Safeguarding governance systems and processes were not effective. Trust-wide safeguarding meetings were not prioritised by all staff and were often poorly attended. Issues with the effectiveness of these meetings had not been raised through the appropriate governance processes.
- At times staff lacked professional curiosity and did not always follow established systems and processes to recognise and identify child protection issues.
- Safeguarding training levels had improved since the last CQC inspection but remained below the trust target, particularly for medical and dental staff.

Summary of findings

- There was an overreliance on individual members of the safeguarding team to ensure that processes to keep children and young people safe were implemented. For example, safeguarding huddle meetings did not take place when a member of the team was not able to lead them, and there were no huddles at weekends when the safeguarding team were not on duty.
- Staff were not supported by regular, formal safeguarding peer review meetings and were not always involved in joint meetings with other agencies to provide input into decision-making for children and young people.
- Learning from incidents was not embedded to ensure that children and young people were protected from similar harm. Even when learning materials had been circulated following incidents, we saw that the same types of incident were still occurring at the time of this inspection.

However:

- The trust's safeguarding children reporting, systems and practices in urgent and emergency care had significantly improved since our last visit.

Urgent and emergency services

Summary of this service

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it, but the systems and processes they used made this difficult.

Leaders did not operate effective governance processes throughout the service and with partner organisations. Staff did not always take opportunities to meet, discuss and learn from the performance of the service.

Detailed findings from this inspection

Is the service safe?

Although staff understood their responsibilities in relation to safeguarding children and young people, the trust's safeguarding children processes, procedures and practices did not support the identification and protection of children and young people who may be at risk.

Safeguarding and protection from abuse

We saw that record keeping was generally of a good standard. Staff utilised the think family approach and made enquiries about patients, who they were with, who else lived in their home and the history of the condition they came to the Urgent and Emergency Care Centre (UECC) with. However in the children's notes we reviewed, they showed that this 'think family' approach was less rigorous in the minor injuries stream than when children were seen by the paediatric nursing team in the department.

However, in four cases of the 16 that we looked at, children were not referred to the paediatric liaison nurse despite meeting the criteria for a referral. In three of the 16 attendances, the electronic system used by GPs and social care was not checked.

We saw that when adults came to the emergency department because of mental illness or domestic violence, the team did not always check who else lived in the house, and whether any children were at risk of harm as a result.

However, we also saw some good practice. For example, we reviewed the notes of a child who had been brought in by a family member following an injury. The triage nurse completed a detailed history, including full details of all the names and addresses of significant people in the child's life. Wider record searches demonstrating good professional curiosity revealed a history of at least one adult being violent in the home. In one example, clinicians were suspicious that the child's injury had been deliberately caused, and the correct referrals were made. Full copies of all decisions and referrals were available in the child's notes.

We checked five referrals to the local council's safeguarding team, all of which had been made by nursing staff. These contained sufficient details to articulate the risk to the child, and in three of the five cases, included relevant information about other people living with the child.

Staff told us that safeguarding practices had improved in the department since our last inspection. They cited daily safeguarding huddles and a weekly safeguarding meeting as evidence of improvement in the visibility of safeguarding practices and processes. Once a month, the weekly safeguarding meeting had an extended invite, open to partners in social care, mental health and primary care.

We saw that notes of safeguarding huddles were not detailed, not completed by staff working in UECC, and attendance was not routinely recorded. Safeguarding huddles provided an opportunity for all members of the team to come together to share any current concerns about children and young people. In a sample two-week period between 1 and

Urgent and emergency services

14 April 2020, physical huddles did not take place due to Covid-19 and we were told that these were replaced during this period by 'virtual huddles' to lower the risk of the spread of infection. On six occasions a 'virtual huddle' (a telephone call to UECC from the paediatric liaison nurse) did take place, but notes were very limited, and on the remaining dates there was no record of any huddle. The trust lacked assurance that the processes they had put in place following our last inspection were effective.

Paediatric liaison nurse duties included the management of all incoming referrals and running daily safeguarding huddles in UECC and the children's ward. A paediatric liaison nurse post was vacant and the existing postholder's workload was substantial. Much of the role involved chasing up and identifying those children who had fallen through the gaps in the differing records systems. For example, the paediatric liaison nurse had recently checked manually through the previous six months of children's attendances in UECC to identify any children on a specific pathway who had been missed. This meant there were potentially missed opportunities to safeguard children when they attended the hospital.

Staff told us there was no comprehensive system for referring dependent children of vulnerable adults for review, and they had no way of quantifying how many referrals from UECC had been missed. They had planned audit work of referral practices and system checks, but explained they had not been able to put this in place due to a lack of resource.

Some of the incidents occurring in the previous twelve months relating to safeguarding children involved locum doctors who did not permanently work at the trust. We heard differing accounts from staff of whose responsibility it would be to ensure that people working in the department had received appropriate safeguarding training. For example, one doctor told us that they would not personally check a locum doctor's competency as this would be done centrally by the human resources team. Another told us that they would ask the locum doctor directly. They added that they used to ask locum doctors to sign a checklist confirming that they had the correct safeguarding training, but that this no longer happened. Doctors confirmed that their locum colleagues working in UECC had access to the trust intranet site where safeguarding documentation and policies were stored, and a new starter safeguarding pack was provided.

The team took part in the Royal College of Emergency Medicine (RCEM) audit on self-harm in relation to mental health but had not yet received any feedback from the audit findings from the relevant external body. No wider audits of self-harm pathways for 15 to 18 year olds had been completed. The child protection medical assessment policy was not complete and was in draft form. This had not been ratified but did cover provision for all children up to the age of 18, seven days a week.

Clinical staff did not know if there was a policy in place for people who came to the emergency department regularly. This meant that they were not being consistently guided on how and when to refer a child who had been brought to UECC multiple times to the safeguarding team. However, they explained that a frequent attender would count as anyone attending more than three times in 12 months.

Staff safeguarding children training at Level 3 was at 90% compliance for medical and dental staff, which was above the trust's 85% target. Compliance for non-medical staff was 95.7%.

Longstanding cultural issues between UECC and the children's ward were acknowledged by staff at all levels. Communication between the two areas had been at times challenging, and supportive, collaborative working was not routinely taking place. Staff working in both areas spoke of recent changes in key posts which they felt had begun to cement closer joint working and shift culture through better understanding of each department's role and working practices. Senior leaders, managers and staff explained that there was still more work to do.

Is the service well-led?

Governance and Management

Urgent and emergency services

Minutes of the last five strategic safeguarding group meetings, held quarterly, showed that these meetings had not been quorate during the period July 2019 to April 2020. Attendance ranged from six to 12 people, including some external agencies. During this time, no trust medical staff had attended.

Minutes of the last year's safeguarding operational group showed that this meeting had not been quorate since August 2019. One member of medical staff had attended in March 2020 and two in May 2020. No other medical staff had attended in the previous year. Minutes of meetings were not always available when needed, with one set of minutes (April 2020) described as missing (it was later confirmed that the meeting had been cancelled) and June's minutes not available as they had not yet been completed when requested by CQC three weeks later.

The safeguarding operations and strategic groups fed into the trust-wide clinical governance group. We reviewed the minutes of this group for the previous 12 months. Safeguarding was a standing agenda item every quarter and featured on the November 2019 and May 2020 agendas. Discussion recorded in the minutes focused on staff training levels.

It was not recorded in the clinical governance group meeting minutes that there were any concerns about the efficacy, quoracy or format of either safeguarding group, nor did the clinical governance group escalate any concerns regarding safeguarding to either the quality assurance committee or board of directors. As a result, there was no 'ward to board' oversight of safeguarding, and issues of quoracy and poor engagement from medical staff was not brought to the attention of the executive team or board through governance mechanisms.

Three risks relating to safeguarding were on the trust risk register at the time of this inspection. These were; social care referrals were not generating receipt emails, poor evidence of implementation of the Mental Capacity Act (this does not apply to children under the age of 16), and staff training levels. We were concerned that the issues we found during this inspection had not been identified or recognised by the trust so that mitigating action could be implemented in a timely manner.

The trust was required to submit a Rotherham partners self-assessment document as evidence of their effectiveness once every two years. The trust's last document, submitted in December 2019, did not match our findings; for example the trust self-assessed at the highest level for 'effective supervision for staff relating to their safeguarding responsibilities' when there was no regular, minuted and structured safeguarding peer supervision in place for medical staff. This was another example where the trust were not fully sighted on the concerns highlighted in this report.

Culture of the organisation

The culture surrounding safeguarding children in the trust was poor. Staff did not prioritise keeping their skills and knowledge up to date and safeguarding children was not 'everybody's business'. This was reflected in the fact that training compliance across the trust was low, although this was better in UECC. Safeguarding operational and strategic meetings were poorly attended and the safeguarding champions programme had poor attendance at meetings prior to the Covid-19 period. We saw in some cases poor practices in relation to safeguarding children with policies and procedures not being implemented or adhered to.

We saw examples of named safeguarding professionals raising the profile of safeguarding through initiatives such as seven-minute briefings and changes to the trust intranet, but the team had not fully evaluated the changes they made to ensure that this was what staff working in operational clinical roles wanted or needed and that these were working effectively.

Areas for improvement

Action the trust MUST take to improve

Urgent and emergency services

- The trust must ensure that formal supervision and peer review processes for safeguarding children are in place. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are accessible by all who need to do so. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are complete and contemporaneous, including sufficient information about everyone living in the household. Regulation 13 (2).
- The trust must ensure that safeguarding processes and systems keep people safe 24 hours a day, seven days a week. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are stored in such a way that they are easy to access and enable a practitioner to quickly build up a complete picture of a child's care. Regulation 17 (2) (c).
- The trust must ensure that records used for safeguarding children are regularly audited for quality and completeness. Regulation 17 (2) (a).
- The trust must ensure that there is sufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and quality standards. Regulation 17 (2) (a).
- The trust must ensure that safeguarding governance systems and processes are effective and monitor this regularly. Regulation 17 (2) (a).
- The trust must ensure that meetings where information about safeguarding children is shared are appropriately attended and effective. Regulation 17 (2) (a).
- The trust must ensure that learning from incidents takes place in a timely manner and that this has been embedded. Regulation 17 (2) (a).

Action the trust SHOULD take to improve

- The trust should continue to work with staff in other services where children and young people are seen to reduce cultural issues between individual parts of the organisation.

Maternity

Summary of this service

Staff understood how to protect patients from abuse. Most, but not all staff had training on how to recognise and report abuse and they knew how to apply it, but the systems and processes they used made this difficult.

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff did not always take opportunities to meet, discuss and learn from the performance of the service.

Detailed findings from this inspection

Is the service safe?

Although staff understood their responsibilities in relation to safeguarding children and young people, the trust's safeguarding children processes, procedures and practices did not support the identification and protection of children and young people who may be at risk.

Safeguarding and protection from abuse

We looked at seven sets of records and seven referrals to other agencies for external support.

We saw that maternity records were fragmented and could be difficult to navigate. Community midwives and those working in the hospital used different systems, plus a separate paper pack was used when needed for safeguarding purposes. This led to a risk that midwives could have an incomplete picture of a mother and baby's safeguarding needs. Staff told us that the information they needed was there, but that it could be time consuming to pull the full picture together. A newly appointed digital midwife had been tasked with incorporating the paper pack into the other systems, but this work was in its very early stages. There were no interim measures in place to mitigate this.

In some of the records we looked at, we saw that there was a lack of professional curiosity shown by some staff. For example, a midwife had not fully reviewed a mother's history on the community system, and there was limited consideration of a parent's previous involvement with children's social care.

We checked five referrals to the local council's safeguarding team, all of which had been made by midwives. These contained enough detail about the incident the professional was concerned about and included relevant information about other people living with the unborn or new born child.

The quality of handover information from community midwives to health visitors was inconsistent, and in two of four postnatal cases reviewed there was no evidence of a documented handover or other information sharing with the health visitor. However, community midwives and health visitors we spoke with knew how and when to share information with their colleagues and told us this worked well in practice.

Safeguarding supervision was held every 12 weeks to discuss cases in detail Safeguarding supervision was documented well in one set of records, but in a further six there was no evidence of supervision discussions.

Screening for female genital mutilation (FGM) by community midwives was robust and embedded. All women, regardless of their ethnic or cultural heritage, were asked about genital cutting, piercing or modification at their booking appointment. Standard operating procedures and policies underpinning practice were up to date and appropriate.

Paediatric liaison nurse duties included the management of all incoming referrals and running daily safeguarding huddles. One of the two paediatric liaison nurse posts was vacant and the existing postholder's workload was substantial.

Maternity

We were informed that safeguarding huddles were in the early stages of introduction in maternity services. Safeguarding huddles provided an opportunity for all members of the team to come together to share any current concerns about children and young people.

Staff told us that their compliance with safeguarding training was checked regularly and they received email reminders when needed.

However, trust training compliance in Safeguarding Children Level 3 was 63.4% for medical and dental staff, and 88.7% for non-medical staff. The trust target was 85%. The trust had been unable to access Safeguarding Children Level 4 training due to circumstances relating to Covid-19, and therefore only three of five people requiring Level 4 training as part of their role had received this.

Safeguarding featured prominently in the Rotherham maternity services' preceptorship package, including ensuring that safeguarding study was completed within three months of starting with the trust, and that users could access and complete an electronic safeguarding referral to the local authority. Staff who had recently completed their preceptorship spoke positively about the support they had received.

Is the service well-led?

Governance and Management

Maternity governance meeting minutes showed that the group met regularly, discussed safeguarding as a standing agenda item, and attendance was prioritised.

Audits completed by maternity staff were completed in a timely way and actions including the dissemination of learning were closed on time. For example, a multi-agency audit of female genital mutilation had been completed on time and actions within the trust's control had been completed. Actions reliant on the engagement of other agencies were updated to show what the trust had done to complete actions.

Minutes of the last five strategic safeguarding group meetings, held quarterly, showed that these meetings had not been quorate during the period July 2019 to April 2020. Attendance ranged from six to 12 people, including some external agencies. During this time, no trust medical staff had attended.

Minutes of the last year's safeguarding operations group showed that this meeting had not been quorate since August 2019. One medical staff had attended in March 2020 and two in May 2020. No other medical staff had attended in the previous year. Minutes of meetings were not always available when needed, with one set of minutes (April 2020) described as 'missing' and June's minutes not available as they had not yet been completed when requested by CQC three weeks later.

The safeguarding operational and strategic group fed into the trust-wide clinical governance group. We reviewed the minutes of this group for the previous 12 months. Safeguarding was a standing agenda item every quarter and featured on the November 2019 and May 2020 agendas. Discussion recorded in the minutes focused on staff training levels.

It was not recorded in the clinical governance group minutes that there were any concerns about the efficacy, quoracy or format of either safeguarding group, nor did the clinical governance group escalate any concerns regarding safeguarding to either the quality assurance committee or board of directors. As a result, there was no 'ward to board' oversight of safeguarding, and issues of quoracy and poor engagement from medical staff was not brought to the attention of the executive team or board through governance mechanisms.

Three risks relating to safeguarding were on the trust risk register at the time of this inspection. These were; social care referrals were not generating receipt emails, poor evidence of implementation of the Mental Capacity Act (this does not apply to children), and staff training levels.

Maternity

The trust was required to submit a Rotherham partners self-assessment document as evidence of their effectiveness once every two years. The trust's last document, submitted in December 2019, did not match our findings; for example the trust self-assessed at the highest level for 'effective supervision for staff relating to their safeguarding responsibilities' when there was no regular, minuted and structured safeguarding peer supervision in place for medical staff.

Culture of the organisation

The culture surrounding safeguarding children in the trust was poor. Staff did not prioritise keeping their skills and knowledge up to date and safeguarding children was not 'everybody's business'. This was reflected in the fact that training compliance was low, safeguarding operational and strategic meetings were poorly attended, the safeguarding champions programme had poor attendance at meetings prior to the Covid-19 period, group safeguarding supervision was poorly attended and did not meet guidance in that minutes were not taken, and attendance not recorded.

We saw examples of named safeguarding professionals raising the profile of safeguarding through initiatives such as seven-minute briefings and changes to the trust intranet, but the team had not fully evaluated the changes they made to ensure that this was what staff working in operational clinical roles wanted or needed and that these were working effectively.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure that formal supervision and peer review processes for safeguarding children are in place. Regulation 13 (2).
- The trust must ensure that staff complete safeguarding training in line with trust policy. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are accessible by all who need to do so. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are complete and contemporaneous, including sufficient information about everyone living in the household. Regulation 13 (2).
- The trust must ensure that safeguarding processes and systems keep people safe 24 hours a day, seven days a week. Regulation 13 (2).
- The trust must ensure that there is a robust midwife to health visitor handover particularly for vulnerable families in line with best practice guidance. Regulation 13 (2).
- The trust must ensure that records used for safeguarding children are stored in such a way that they are easy to access and enable a practitioner to quickly build up a complete picture of a child's care. Regulation 17 (2) (c).
- The trust must ensure that records used for safeguarding children are regularly audited for quality and completeness. Regulation 17 (2) (a).
- The trust must ensure that there is sufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and quality standards. Regulation 17 (2) (a).
- The trust must ensure that safeguarding governance systems and processes are effective, and monitor this regularly. Regulation 17 (2) (a).
- The trust must ensure that meetings where information about safeguarding children is shared are appropriately attended and effective. Regulation 17 (2) (a).

Maternity

- The trust must ensure that learning from incidents takes place in a timely manner and that this has been embedded. Regulation 17 (2) (a).

Services for children and young people

Summary of this service

Staff understood how to protect patients from abuse. Most, but not all staff had training on how to recognise and report abuse and they knew how to apply it, but the systems and processes they used made this difficult.

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff did not always take opportunities to meet, discuss and learn from the performance of the service.

Detailed findings from this inspection

Is the service safe?

Although staff understood their responsibilities in relation to safeguarding children and young people, the trust's safeguarding children processes, procedures and practices did not support the identification and protection of children and young people who may be at risk.

Safeguarding and protection from abuse

Records in the children's ward were predominantly held on paper, despite most children arriving from the urgent and emergency care centre (UECC) which used an electronic record. A one-page summary form was completed in UECC and passed to the children's ward at the time of transfer.

The children's ward had access to systems used by other parts of the hospital. Staff needed to check these systems to establish a full picture of a child's care, and we found these checks were not consistently documented as being completed. These checks would alert the team to any safeguarding concerns already known about the child or their family. A lack of checks could mean that important details were not considered by the team, potentially increasing the risk of harm to children and young people. There was a lack of oversight and audit of these checks of other systems and therefore no way of knowing how systemic this issue was.

Children's health records could be held in up to four systems, making it challenging to track children's pathways across the trust.

Risk assessments within the children's assessment unit and children's ward were limited. There was no evidence within records of safeguarding tools such as routine enquiry for domestic abuse to identify or explore risk. In eight out of 14 records reviewed, safeguarding checks within the children's multidisciplinary care record were not consistently completed.

Within children's records, the 'think family' approach was not always evident or consistent. Some records of children with safeguarding concerns contained notes of siblings and wider family members but others did not.

Records were variable in quality, and in some cases, missing significant and important detail about other members of a child's family, or did not provide a full picture of a child's care. We saw notes written retrospectively, up to three days later, despite significant safeguarding concerns relating to that child.

Copies of safeguarding referrals were not always held in children's records and there was an overreliance on members of the safeguarding team to keep track of referrals.

Services for children and young people

In some of the records we tracked, we saw evidence of children who had attended the ward on multiple occasions, often in a short space of time. There was no effective process within the children's assessment unit to alert professionals to frequent attenders or that this was routinely considered by staff. Staff told us they would refer children to the paediatric liaison nurse who would follow this up. There was a lack of professional curiosity and recognition of their own roles and responsibilities by the ward team in safeguarding children.

We checked five referrals to the local authority safeguarding team from the children's ward, all of which had been made by nursing staff. These contained enough detail about the incident the professional was concerned about and included relevant information about other people living with the child.

We saw that notes of safeguarding huddles were not detailed, not completed by staff working in the children's ward, and attendance was not routinely recorded. Safeguarding huddles provided an opportunity for all members of the team to come together to share any current concerns about children and young people. In a sample two-week period between 1 and 14 April 2020, physical huddles did not take place due to Covid-19 and we were told that these were replaced during this period by 'virtual huddles' to lower the risk of infection transmission. On six occasions a 'virtual huddle' (a telephone call to the ward from the paediatric liaison nurse) did take place, but notes were very limited, and on the remaining dates there was no record of any huddle. The trust lacked assurance that the processes they had put in place following our last inspection were effective.

Paediatric liaison nurse duties included the management of all incoming referrals and running daily safeguarding huddles. One of the two paediatric liaison nurse posts was vacant and the existing postholder's workload was heavy as a result. Much of the role involved chasing up and catching those children who had fallen through the gaps in the differing systems. Managers told us they did not have a system for checking if any referrals to paediatric liaison had been missed by staff working over the weekend and relied on the postholder organising a safeguarding huddle on Monday to pick up any missed referrals.

Children aged 16-18 who were placed on adult wards were not tracked by paediatric staff who relied on other specialties to contact them for advice if needed. There were no routine checks on these children by the paediatric team and no system in place to monitor outcomes for these children.

Paediatric medical staff were not receiving regular, structured peer reviews that met the Royal College of Paediatrics and Child Health guidance. Some learning was offered but peer review meetings with a detailed term of reference, minutes and documented attendance were not in place.

Trust staff training levels in Safeguarding Children Level 3 were 63.4% for medical and dental staff, and 88.7% for non-medical staff. The trust target was 85%. The trust had been unable to access Safeguarding Children Level 4 training due to circumstances relating to Covid-19, and therefore only three of five people requiring Level 4 training as part of their role had received this.

Longstanding cultural issues between UECC and the children's ward were acknowledged by staff at all levels. Staff working in both areas spoke of recent changes in key posts which they felt had begun to cement closer joint working and shift culture through better understanding of each department's role and working practices. Senior leaders, managers and staff explained that there was still more work to do.

Is the service well-led?

Governance and Management

Services for children and young people

Audits were not always embedded, and actions were not signed off in a timely way. For example, an audit of contact between parents and children admitted to hospital with safeguarding concerns had been completed in December 2019, eight months after the projected completion date. Five actions to develop multi-agency communication and awareness-raising had not been completed at the time of our inspection.

Minutes of the last five strategic safeguarding group meetings, held quarterly, showed that these meetings were not quorate during the period July 2019 to April 2020. Attendance ranged from six to 12 people, including some external agencies. During this time, no trust medical staff had attended.

Minutes of the last year's safeguarding operations group meeting showed that this meeting had not been quorate since August 2019. Two medical staff had attended in May 2020, and one in March 2020. No other medical staff had attended in the previous year. Minutes of meetings were not always available when needed, with one set of minutes (April 2020) described as 'missing' and June's minutes not available as they had not yet been completed when requested by CQC three weeks later.

The safeguarding operational and strategic groups fed into the trust's clinical governance group. We reviewed the minutes of this group for the previous 12 months. Safeguarding was a standing agenda item every quarter and featured on the November 2019 and May 2020 agendas. Discussion recorded in the minutes focused on staff training levels.

It is not recorded in the clinical governance group minutes that there were any concerns about the efficacy, quoracy or format of either safeguarding group, nor did the clinical governance group escalate any concerns regarding safeguarding to either the quality assurance committee or board of directors. As a result, there was no 'ward to board' oversight of safeguarding, and issues of quoracy and poor engagement from medical staff was not brought to the attention of the executive team or board through governance mechanisms.

Three risks relating to safeguarding were on the trust risk register at the time of this inspection. These were; social care referrals were not generating receipt emails, poor evidence of implementation of the Mental Capacity Act (this does not apply to children), and staff training levels.

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Culture of the organisation

The culture surrounding safeguarding children in the trust was poor. Staff did not prioritise keeping their skills and knowledge up to date and safeguarding children was not 'everybody's business'. This was reflected in the fact that training compliance was low, safeguarding operational and strategic meetings were poorly attended, the safeguarding champions programme had poor attendance at meetings prior to the Covid-19 period, group safeguarding supervision was poorly attended and did not meet guidance in that minutes were not taken, and attendance not recorded.

We saw examples of named safeguarding professionals raising the profile of safeguarding through initiatives such as seven-minute briefings and changes to the trust intranet, but the team had not fully evaluated the changes they made to ensure that this was what staff working in operational clinical roles wanted or needed and that these were working effectively.

Areas for improvement

Action the trust MUST take to improve

Services for children and young people

- The trust must ensure that formal supervision and peer review processes for safeguarding children are in place. Regulation 13 (2).
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- The trust must ensure that staff understand their own roles and responsibilities to safeguard children and young people. Regulation 13 (2).
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- The trust must ensure that there is sufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and quality standards. Regulation 17 (2) (a).
- The trust must ensure that safeguarding governance systems and processes are effective, and monitor this regularly. Regulation 17 (2) (a).
- The trust must ensure that meetings where information about safeguarding children is shared are appropriately attended and effective. Regulation 17 (2) (a).
- The trust must ensure that learning from incidents takes place in a timely manner and that this has been embedded. Regulation 17 (2) (a).

Action the trust SHOULD take to improve

- The trust should ensure that 16-18-year-olds who are admitted to adult wards receive appropriate and timely input from the paediatric team.
- The trust should continue to work with staff to reduce cultural issues between individual parts of the organisation.

Our inspection team

The team included five inspectors, two inspection managers and a specialist in safeguarding children and young people. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services Nursing care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Maternity and midwifery services Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance