The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at Russells Hall Hospital

Requires Improvement 

Russells Hall hospital is part of The Dudley Group NHS Foundation Trust. The trust is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and smaller, but growing, communities in South Staffordshire and Wyre Forest. The trust serves a population of around 450,000 people from 3 hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. The trust provides the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. The trust also provides specialist adult community-based care in patients' homes and in more than 40 centres in the Dudley Metropolitan Borough Council community.

We carried out unannounced inspection of the following acute services provided by the trust at Russells Hall hospital.

- Services for children and young people.
- Urgent and Emergency care.

We did not inspect any other services.

How we carried out the inspection

Urgent and Emergency care at Russells Hall Hospital

We inspected this service on 17 and 18 May 2023. This was an unannounced full core service inspection looking at urgent and emergency care. We visited all areas of the urgent and emergency care (U&E) department including the waiting rooms, triage, resuscitation, minors, majors, and children's urgent and emergency care (U&E) department.

The team that inspected the service comprised 1 CQC hospitals inspector, 1 CQC children's service inspector and 2 specialist advisors with expertise in emergency medicine and children's emergency medical care.

During our inspection we spoke with 24 staff members including nursing staff, safeguarding leads, healthcare assistants, ambulance staff, cleaners, doctors and managers. We spoke to 15 patients, and we reviewed 5 adult patient records, 5 children's patient records, 5 medication charts and we reviewed 11 previous case files for children's paediatric care.

Childrens and young people's services at Russells Hall Hospital

We carried out an unannounced full core service inspection of the Children and Young People's service on the 7 and 8 June 2023.

During the inspection, we looked at all 5 key lines of enquiry which were safe, effective, caring, responsive and well-led.

The team that inspected the service comprised of 1 CQC hospitals inspector, 1 CQC children service inspector and 2 specialist advisors with expertise in children's and neonatal services.

Our findings

We spoke with 32 staff including senior leaders, matrons, doctors, nurses, health care assistants, porters, infection control leads, safeguarding leads and the transitional lead. We spoke with 7 families and 2 young people. We also looked at 65 patient records.

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.

Urgent and emergency services

Requires Improvement 

The Urgent and Emergency Care Service is located at Russells Hall Hospital and is a 24/7 service. This is the major Urgent and Emergency Care Service in the area and serves the population of Dudley and surrounding areas. The Urgent and Emergency Care Service sees approximately 97,000 patients per annum.

The Urgent and Emergency Care Department at Russells Hall Hospital consists of:

- An urgent care centre
- Two main reception areas
- A majors department
- A minors department and waiting room
- See and treat area
- Triage area
- Resuscitation area
- Childrens urgent and emergency care (U&E) department

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always have training in key skills. Mandatory training levels did not always meet the trust target of 90%.
- The service was not meeting its target of 95% of patients offloaded from ambulances within 15 minutes.
- Medical staff did not always have the training in safeguarding to the appropriate level.
- The resuscitation area of the Urgent and Emergency Care Department did not meet the needs of the patients attending for urgent treatment.
- The recruitment, development and retention of paediatric nursing staff was a risk to the future safe staffing of the department.
- The recruitment and retention of medical staff was a risk to the future safe staffing of the department. However, locum and bank staff were used to mitigate the risk to patient safety.
- Performance in relation to the service's deteriorating patient pathway required improvement.
- The family structure was not recorded in children's records, this did not allow for the child to be seen in the context of the family. This should be recorded and discussed.

However:

- Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Urgent and emergency services

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- 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 patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always make sure everyone completed it.

The mandatory training the service provided was comprehensive and met the needs of patients and staff. Mandatory training covered the appropriate subjects including safeguarding, basic life support, advance life support, infection prevention control and manual handling.

However, mandatory training rates did not always meet the trust target of 90% compliance. Completion rates for nursing staff in the minors and majors urgent and emergency care (U&E) department were mostly between 80% and 100%, with an average of 86%. Of the 19 modules, 6 met the compliance target and 11 were 70% to 89% compliant. Basic life support for paediatrics training compliance was 63% for nursing staff in the majors U&E.

Medical staff received, but did not always keep up to date with their mandatory training. Of the 19 modules, 10 met the trust target for compliance of 90% or above. Of the 9 modules which did not meet the trust target the lowest was Mental Capacity Act training at 75% compliance.

Mandatory training rates for paediatric nursing staff were mostly between 90% and 100% complaint with mandatory training. However, paediatric nursing staff had completion rates for Adult Basic Life Support and Childrens Basic Life Support were 73% and 69% compliant, respectively.

The trust provided life support training for nursing and medical staff. The level of training was dependent on the banding or level of the staff. The courses were: Advanced Life Support training (ALS), Advance Paediatric Life Support Training

(APLS), European Paediatric Advanced Life Support Training (EPALS), Intermediate Life Support training (ILS) and Paediatric Intermediate Life Support training (PILS). Of the 18 consultants working in the U&E department, 5 had completed ALS training, all consultants had completed EPALS or APLS. Completion rates for nursing staff for PILS training was 78.5% and 58.5% of Care Support Workers had completed the training. We were told that some staff had moved departments or were not at work to complete the training and there were plans for the training to be completed. The completion rate for EPALS was 21.4% for nursing staff. However, some of the staff in the nursing team were new recruits or there were plans for them to complete the training.

Following our inspection, we saw evidence that training compliance figures were discussed at monthly governance meetings, with plans for increasing completion of training.

Clinical staff received training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were responsible for booking training session themselves and could choose to either complete in work time or at home and claim time back from the service.

Most staff groups had completed training such as autism awareness and mental health law. However, staff had not yet completed the Oliver McGowan training or similar.

The trust was in discussion regarding the Oliver McGowan training; the lead nurse for learning disabilities and the head of learning and organisational development were considering the most appropriate way, to ensure the training was provided across the trust. There was some learning element to the training which some staff had undertaken but this had not yet been established.

Safeguarding

Staff understood how to protect patients 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.

Staff received training specific for their role on how to recognise and report abuse. Training compliance data for nursing staff in the majors U&E department showed that overall mandatory training completion rate was 81% for safeguarding adults' level 2 and 91% for safeguarding adults' level 3. In the minors U&E, data showed that overall mandatory training completion was 83% for safeguarding adults' level 2 and 72% for safeguarding adults' level 3, this was significantly below the trust target of 90%.

Nursing staff also completed training for safeguarding children and the level 2 completion rate for the majors U&E department was 82% and safeguarding children level 3 completion rate was 96%. Training data for minors U&E showed the overall mandatory training completion rate for safeguarding children level 2 was 86%, and for safeguarding children level 3 was 100%.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff compliance levels for completion of safeguarding training were 84% for safeguarding adults' level 2 and 90% for safeguarding adults' level 3. Medical staff also completed training for safeguarding children and the level 2 completion rate was 100% and safeguarding children level 3 completion rate was 81%.

Urgent and emergency services

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke to could give us specific examples of taking action to safeguard a patient from abuse, the process and who they would contact for support. Safeguarding policies were clear, easy to use and up to date. All the staff we spoke to were able to demonstrate their knowledge of safeguarding policies and procedures and stated that assessment and referral paperwork was clear and easy to follow. Staff had received reviewed safeguarding and professional curiosity training and were able to demonstrate a knowledge of the training and accompanying video. Information we received following our inspection showed that the trust had held training sessions in professional curiosity during March 2023 and that there had been a good level of attendance by staff across various medical disciplines including U&E. Staff during our inspection could give examples of where they had used safeguarding processes to protect an adult or child from harm and stated that the safeguarding team were visible in the departments and available to give advice and guidance.

Following our inspection, the trust advised us that level 4 safeguarding training had been completed by safeguarding leads, the head of safeguarding and certain named doctors and lead nurses. The Chief Nurse was level 5 safeguarding trained as a director responsible for safeguarding and could have issues escalated to them if required. Arrangements within trust for specialist safeguarding advice out of hours was to call Multi-agency Safeguarding Hub within the local authority.

Safeguarding referrals and professional curiosity were discussed at the morning staff meeting we attended during our inspection. At these meetings staff were reminded of the process for making safeguarding referrals and the importance of continuing to have conversations with patients about their circumstances, support needs or any safety concerns. Staff told us that the triage system would flag any children who frequently attended the service, and this would be escalated to a consultant for review.

Staff followed safe procedures for children visiting the ward. The trust had a clear policy for children attending the U&E department unaccompanied which included trying to establish how they arrived at the hospital, informing the trust security team of the child, escalation of the matter to a manager and if necessary contacting Children's Social Care and the Police for further advice.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke to in all areas of the U&E department could give us specific examples of taking action to safeguard a patient from abuse, the process and who they would contact for support. Staff we spoke to in the children's area were knowledgeable about safeguarding and how to use the referral process. The lead for safeguarding in the children's area told us they had been offering 1 to 1 sessions with staff, including international nurses to help them to embed learning from training. We saw evidence where on 2 occasions the nursing team had assessed a family as needing support and a referral had been done to external agencies. The medical staff in the department had also supported the referrals. Staff told us they felt confident to discuss the need for support or a safeguarding referral with patients and their family, and had received specific training for this aspect of their role. There was also a policy regarding the action to be taken if a child had left the department without being seen and for suspected child abduction.

Following our last inspection of the children's U&E department, we found there had been an overall improvement in the reporting of safeguarding which has been supported by the introduction of a mandatory safeguarding template with focused questions and now includes body maps to indicate injuries. These templates were used consistently to include self-harming and head injury.

Urgent and emergency services

Paediatric U&E attendances from the previous day were reviewed by the Safeguarding Team, and information shared with appropriate health professionals and agencies if necessary. During our inspection, we saw evidence that the number of referrals to children's services post attendance at U&E had reduced following the training given and the increased visibility of the safeguarding team in departments. This indicated that patients who needed to be referred were being identified.

We saw noticeboards in U&E reception areas for both adults and children with details of support for families, such as from domestic violence or with the details of the local children's and adolescent mental health services. Staff areas had noticeboards which displayed details of safeguarding procedures and contacts. The trusts internal systems had links to safeguarding documents, guidance and training.

There was a children, young person, and adult restraint procedure in place. The procedure contained a restrictive practice guidance flowchart, identified types of restraint, and contained documentation to record a post restraint review.

Paediatric nursing staff had completed safeguarding adult level 2 at a completion rate of 96%, safeguarding children level 2 had been completed to 100% and safeguarding children level 3 had been completed to 92%.

There was an improving picture in the quality of recording of safeguarding discussions or actions within the children's U&E records when compared to a previous CQC inspection that focussed on safeguarding. Staff we spoke to told us that these improvements is had been supported by the introduction of a new mandatory safeguarding template for staff to use, with focused questions and a body map to indicate injuries where required. A review children's patient files noted that these forms were used consistently at each assessment point with in the main and children's U&E department.

There was evidence of increased professional curiosity within the patient records in children's U&E, but this was still an area for further improvement within the main U&E department. From October to December 2022, the service had missed making 49 referrals to an external agency for support of a patient, child or dependent. However, since the service had introduced 1 to1 safeguarding supervision in December 2022, and rolled out professional curiosity training in March 2023, the number of missed referrals had reduced to 25, from January to March 2023. There was a process in place for monitoring missed referrals and ensuring the department responsible completed the referral where appropriate. During our inspection we saw evidence that after a safeguarding assessment a referral had been made to a child's GP for follow up and the monitor the child wellbeing.

It was noted that the family structure was not recorded children's records, and this did not allow for children to be seen in the context of the family and consider other circumstances that may have led to the attendance at children's U&E. This should be recorded and discussed. However, all the records we viewed contained the voice of the child as part of the mandatory assessment completion.

We attended the children's daily safety meeting which was held with the manager for children's U&E and the Childrens Ward, a safeguarding lead, a Consultant, a Matron, nurse in charge and support staff. The meeting was well organised. Staffing and capacity for the day were discussed, there was a review of safeguarding cases and discharge plans and referrals to internal departments or external agencies were considered where appropriate.

There were still improvements to be made for the 16 to 18 year olds patient pathway as these children can sometimes be seen as 'hidden'. The trust told us that once aged 16, irrespective of school status, a patient would be seen in adult majors or minors department, unless under continuing care of paediatric department.

Urgent and emergency services

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained. All areas and equipment where visibly clean. The patient and staff toilet areas were clean and well maintained. Laundry and sluice rooms we visited were clean and free from clutter.

The service generally performed well for cleanliness. The service completed monthly infection prevention and control audits and data we saw following the inspection showed that areas for improvement were identified during the audits and action plans put in place. Hand hygiene audits for March, April and May 2023 were 100% and the leaders and staff were aware of the audits.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were sufficient quantities of PPE available, and staff followed infection prevention control principles. Wash basins, hand gel and handwashing liquid were available throughout the department in all areas. There were notices reminding staff and patients of the importance of hand washing the use of hand gel. Staff were bare below the elbows as was required in clinical areas and followed other principles of infection prevention control, such as long hair tied up and the use of aprons and masks where required.

Staff received training on Infection Prevention and Control (IPC) as part of their mandatory training and data we received following inspection showed that 100% of non-clinical staff had completed this training. The IPC training had also been completed by 91% of clinical staff in the U&E majors and 96% of clinical staff in children's U&E. However, IPC training had only been completed by 82% of staff in the minor's emergency unit and 87% of medical staff, missing the trust target of 90%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The trust employed a team for daily cleaning and had an external contract for deep cleans and cleaning of specialist equipment. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw 'I am clean' stickers being used in most areas, but some had been missed in the majors U&E department. Patient trolleys which had been deep cleaned were dated with a plastic tag.

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.

The design of the environment mostly followed national guidance. All patients attending for treatment including paediatric patients, accessed the service via the Emergency Treatment Centre (ETC) entrance. This was part of the U&E department and was contracted out by the trust to an external health care provider, patients attending the ETC were then streamlined to the correct part of the main urgent and emergency care (U&E) department. The ETC area had 7 treatment rooms, 2 rooms allocated for assessment of patients by a nurse, 2 rooms for assessment by an Advance Medical Practitioner (AMP), a rapid assessment room, 2 rooms allocated to GPs, a waiting room with 2 reception desks. At the ETC reception a member of nursing staff would triage and refer patients to the correct area either to remain in the ETC for a consultation with either a GP or AMP, go to the urgent and emergency care (U&E) department area or for rapid assessment. The ETC area had ample seating for the number of patients attending during our visit but staff we spoke to told us that during peak times such as winter, patients would be standing or queuing outside the doors due to the higher volume of attendances.

Urgent and emergency services

The U&E department had a reception desk where patients referred from the ETC booked in with information from the ETC explaining why they had attended and their presenting medical need. The area had ample seating and the receptionist had a full view of the waiting room.

Both reception areas had notice boards detailing the patient flow for the U&E department and guidance on how to report abuse or domestic violence. There was also information on baby safety, such as safe sleeping, feeding and signs of neglect. Both reception areas supplied hand gel, wipes and face masks if needed.

Once children had been triaged they could either be seen by an AMP or GP if appropriate or would be transferred to the children's U&E which was separate from the adult's U&E area. This department was clean and bright with age-appropriate decorations. There were secure door controls in place for entrance and exit to the department. There were toys and books available for younger children to play with, and there was a separate games room for older children which had been designed. Ambulance staff took patients arriving by ambulance to a separate entrance from those patients who had walked in. The ambulance bay entrance was close to the resuscitation area and the major's department for the U&E department.

However, the resuscitation area of the department had 4 bays which staff told us would often be fully utilised and 1 of these bays was intended for paediatric patients who would be taken to an alternate resuscitation room if this bay was in use. However, following the inspection leaders told us this was not correct and that there was a separate paediatric resus area is used exclusively for paediatric patients, only if it was occupied would the second paediatric patient be diverted.

The resuscitation area had a large amount of equipment which was needed during an emergency procedure but as there was inadequate space for storage and the resuscitation area appeared cluttered. During our inspection staff explained plans had been in development prior to the COVID-19 pandemic for a building a new resuscitation area, but these had to be suspended. Follow up conversations with the trust executive team confirmed that the plans to renovate the resuscitation area were resubmitted but due to inflation and the cost on building materials they would not be able to build the full redesign of the area as previously planned.

The U&E care area was comprised of a major's area, minors' area, an isolation ward. The major's department was tidy and well organised there were 14 bays situated around a central desk area for staff. There were also 2 areas used by occupational therapists, a patient family room and room for the onsite mental health team to use a for assessments. The minor's area of the department had a reception area, waiting room that met the needs of the patients attending and 3 bay areas for treatment.

The department also had a Rapid Assessment Triage area and a 'See and Treat' Area.

The service had suitable facilities to meet the needs of patients' families. The department had a room provided for friends and family which was within the main department but far enough away to be private and allow families time to be together if needed.

Patients could reach call bells and staff responded quickly when called. Staff carried out daily safety checks of specialist equipment. There was enough suitable equipment in the U&E department to help staff safely take care of patients. Staff had access to emergency resuscitation trolleys for adults and children. During our inspection we checked the

resuscitation trolleys in both the Majors, Minors and Paediatric U&E. All of the trolleys had the required equipment to treat a patient in an emergency and the equipment was within the expiry date. Each trolley had a folder with pictures details the equipment that should be in the trolley. Daily safety checks had been completed on each trolley. We checked 9 pieces of equipment and an electrical safety testing programme had been completed in line with guidelines.

The mental health room had 2 doors, 1 door opened to the main majors U&E and the other to the corridor. This room was clean and tidy and had no ligature points. The department also had 3 bays which were 'ligature light' and where possible were used for patients who attended the U&E department with mental health concerns. The cubicles had removable patient monitors, oxygen and suction fixtures, and curtains were held in place with magnetic anti-ligature rails. The cubicles were in clear sight of staff workstations. Following a previous serious incident, the department now had ligature shears and had plans in place to provide training for the use of the shears. Department heads showed us the actions they had taken to address patient safety while the ligature shear training was being embedded.

During our inspection we saw that fire doors were clear and easy to access. Fire evacuation procedures were up to date.

Staff disposed of clinical waste safely. There were designated bins for general and clinical waste. Sharps buckets for disposal of instruments were available throughout the department.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

The department had an Emergency Physician in Charge (EPIC), this role was allocated at the start of each shift to a Senior Consultant or Doctor within the department. The role of the EPIC is to carry out the immediate assessment and treatment of patients with serious and life-threatening illnesses and injuries and to have clinical oversight of the patients in the department. The EPIC was seated in a central area for staff to be able to review any patients that nursing or medical staff had a concern about or discuss any treatment or discharge plans.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff knew about and dealt with any specific risk issues. The service had a deteriorating patient pathway (DPP) on an internal electronic application, an alert was triggered by a high National Early Warning Score 2 (NEWS2) or Paediatric Early Warning Score (PEWS). The alert required a Senior Clinician to acknowledge the alert for patient review. Staff we spoke to understood DPP and told us they felt this gave them the reassurance that the patient score had been acknowledged and that the appropriate action would be taken by the clinician.

The service operated a 'Red Card' procedure for priority patients with life threatening conditions, who require immediate assessment within the U&E department. The patient would show the card at the reception desk and with their patient notes and an accompanying clinician would be put ahead of the waiting list or seen immediately. Staff we spoke to on the reception desk areas for the Emergency Treatment Centre and the U&E department understood the procedure and there were signs displayed for patients presenting a red card.

Staff completed risk assessments for each patient on admission, using an Electronic Patient Record (EPR) recognised tool, and reviewed this regularly, including after any incident. Patient notes we reviewed during our inspection and audit data we received following our inspection showed that patient risk assessments had been completed 78% of the time for adult patients and for children 94.7%. These both scored below the trust's compliance figure of 100%. Minutes of the Clinical Governance Meetings held monthly withing the trust detailed that clinical audits were discussed at meetings and action plans completed.

Urgent and emergency services

We were provided with the NEWS2/PEWS audits for the previous 6 months. These showed that the rates of patients being assessed was within 30 minutes of arrival in the department was between 73% and 100%. During our inspection, the U&E matron demonstrated the trust system of audits and the actions allocated to staff members for improvement. The sepsis audit for the same time period showed that screening was between 94% to 100% for 5 of the 6 months, but that this had dropped to 65% in March 2023. In most cases, antibiotics had been administered within 60 minutes with the exception of April 2023 where this was 75% not meeting the trust target 100%.

In the children's U&E was saw the use of PEWS escalation charts which detailed the processes to follow where the trigger criteria is met and use of the S (Situation) B (Background) A (Assessment) R (Recommendation) framework which is a recognised risk assessment tool.

Staff in all emergency departments had access to guidance on the management of emergency conditions, such as the management of suspected or confirmed Acute Coronary syndrome and the management of alcohol or substance use.

At the time of our inspection during feedback to the trust we escalated that we had noticed 1 patient had been in the department for a long time and had not been moved to a bed. We requested the process for assessing patients who might need to be moved to a bed, this is an important assessment to monitor any existing pressure sores or the possible development of deteriorating skin. The service explained this was done using clinical judgement depending on the patient mobility, acuity with a risk assessment approach but that a procedure for staff to follow was in development.

Staff assessed patients' mental health using the Close Observation Scoring Tool which assessed 5 factors: psychological, cognitive impairment, distressed behaviour, environment and falls. The scores ranged from 0 to 15, a score of between 12 and 15 would prompt the staff to request 1 to 1 observation for the patient. Staff were able to explain the use of this tool and actions to be taken. The record of this observation would then be scanned onto the Electronic Patient Record (EPR).

The service had 24-hour access to mental health liaison and specialist mental health support. staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff referred any patients who required a support to the mental health liaison and specialist mental health teams and patients where necessary the mental capacity tool was completed. During our inspection, we saw the mental health liaison team attending to a patient following referral from U&E staff. The mental health team assessed the patient who had discussed the patient's assessment and plan for support with the referring U&E staff.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed safety huddles to discuss the handover of patients from the previous shift and capacity or flow issues. These meetings were well run and organised.

Nurse staffing

The main adult U&E service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the staffing in the children's U&E was on the service risk register.

Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The main U&E department had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service had low levels of agency staff use and where needed, managers

requested staff who had previously worked in the department to cover shifts. Data we received following the inspection for the previous 5 months from January to May 2023 showed that of the total staffing, bank staff had been used 19% of the time to cover shifts and agency staff had been used 0.3% of the time. Managers made sure all bank and agency staff had a full induction and understood the service.

The matron allocated to the department was in an interim role to cover staff sickness in the post. Managers at the service told us that the trust had plans to recruit 4 Deputy Matrons in May 2023.

We attended the morning handover meeting and saw that tasks were assigned to staff at this meeting and any staff shortages were discussed. Staff knew where they would be working for the day.

Staffing for the children's U&E was on the trust risk register. The staffing for the department, in line with national guidelines, should have been 2 band 6 paediatric nurses, 1 Emergency Severity Index (ESI) nurse and 1 Childrens Support Worker (CSW) for the daytime shift and 1 ESI triage nurse and 2 band 6 paediatric nurses per night shift. The service was not always able to resource these shifts to the required levels from the established staff and would use bank or agency staff. There were 2 band 6 nurse vacancies and 2 band 5 nurse vacancies which were being recruited. The staff sickness in the department was high, for the months February to March 2023 the average sickness in the department was 11.02%, which was high in comparison to other U&E care departments. The service was taking action to mitigate the staffing risk, such as requesting any gaps in the rota were covered by staff who had worked previously in the children's U&E or the General Childrens Ward. The trust had recognised that one of the issues for the retention of staff within the children's U&E was the lack of opportunities for children's U&E staff to develop in their careers and plans were in place to review these opportunities.

The service had low and/or reducing turnover rates. The nursing turnover rate was 6.1%.

Medical staffing

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

The service mostly had enough medical staff to keep patients safe and relied on bank and agency staff to support safe staffing across the service for nurse staffing.

The department had 18 consultants, 17 Middle grade or training doctors, 27 Senior House Officers (SHO) and 9 Advance Clinical Practitioners (ACP). However, the service had high turnover rates for medical staff with vacancies for 5 SHO positions, 4 ACP staff and 7 middle grade or training doctors.

Managers could access locums when they needed additional medical staff. They had an average of 13 shifts covered by locums per week, and sometimes used up to 2 agency doctors to cover shifts but would ensure these were always the same doctors. The SHO and Advanced Clinical Practitioner shifts were covered by internal bank staff at weekends mainly and this could be up to 12 shifts.

The service always had a consultant on call during evenings and weekends. However, staff we spoke to told us there was no specific consultant allocated to the children's and a paediatric consultant was available on call. U&E department and that a consultant would need to be requested from the main U&E department if needed.

Sickness rates for medical staff were low, the data for February 2023 showed a sickness rate for 2.64% for medical staff, 3.49% for March, and 0.33% for April 2023.

Consultants in the department told us that junior medical staff were allocated to the children's U&E daily then a consultant was on bleep for the department to cover between 8am and 12pm.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The department used an Electronic Patient Record system (EPR). Records we viewed during the inspection were up to date. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. We saw that information was accessible to all staff and was being used appropriately. Relevant forms were available electronically, such as National Early Warning Score 2 and Paediatric Early Warning Score.

Members of the inspection team who viewed records in the adult U&E department and the children's U&E department felt that these were kept well and completed comprehensively. The department complete audits in all departments of the notes and informed staff of any action to be taken as part of the audit outcomes.

We saw that nursing staff in the children's U&E were using oral fluid challenge charts to monitor the fluid intake of children to prevent them becoming dehydrated and unwell. Staff were following the trust guidance on using these charts and that department record audits had shown that for the 3 months were audits had been completed (February, April and May 2023) these were complaint to 100%.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the U&E department did not have a medicines fridge in the main medicines' storeroom, the fridge would be used for storing emergency medication, such as insulin. The service had access to a medicine's fridge, and we saw evidence that changes had been made to the main U&E medicines store cupboard to accommodate a fridge and also a purchase order request for the fridge was provided to us following our inspection. The department had a dedicated pharmacy technician allocated to check stock levels, complete audits and ensure that systems and processes for the safe prescribing of medications were being followed. Medicines audits were completed quarterly.

Staff learned from safety alerts and incidents to improve practice. An audit had been conducted to monitor the use of Penthrox, which is licensed for the emergency relief of moderate to severe pain in conscious adult patients, presenting with trauma and associated pain. The use of Penthrox had been reviewed on 277 patients and 3 patients had been prescribed Penthrox inappropriately for a non-trauma related pain, these patients had been referred to a U&E consultant for review and the findings of the review would be feedback to the prescribing clinicians for learning. This is a best practice process for the department and learning for clinical teams.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 5 medication charts, and these had been completed correctly including specific times and route of administration. Patients' allergies had been recorded where appropriate.

Staff stored and managed all medicines and prescribing documents safely. We checked 3 controlled drug store cupboards, and all medicines were in date, stored correctly and documentation had been completed. Following our

inspection data provided to us showed that the pharmacy team completed a quarterly comprehensive audit of the controlled drug and an annual general medicines cupboard audit in all areas of the U&E department including the children's U&E. These audits and actions where documented and we saw trust wide learning that had been shared following the audit outcomes with response to the organisation of medicine cupboards and stock control.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Each patient's medicines history was taken on admission to U&E and this history had been recorded on the medical records we reviewed.

Staff learned from safety alerts and incidents to improve practice. The service had a Safe Medicines Practice Group. The role of the group included but was not limited to: improving reporting and learning from medication error incidents, review audit data, to reduce medication errors and promote best practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff we spoke to during our inspection explained the reporting process and they types of incidents they would report. Staff told us they received feedback and learning from incidents. Staff said they felt comfortable with escalating incidents to a higher management level if they felt their concerns were not being addressed.

The department has had no never events in the last 12 months.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. We saw evidence that learning from a previous patient fall incident which had resulted in a fracture to the left neck of femur had been shared within the team. Learning included completing a falls assessment within an hour of a patient attending the department, and a post fall document to be completed by U&E Clinicians on assessing patients post fall. Staff also spoke to us about training they had received following an incident in the department which had led to a patient death. They explained the training they had received and the changes to procedures to improve patient safety.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Evidence provided to use following our inspection gave details of instances where duty of candour had been carried out and patients or family affected by incidents had been contacted.

Managers debriefed and supported staff after any serious incident. Staff told us that following a serious incident in the U&E department they had been supported and that the member of staff directly affected had been supported by the management team.

Urgent and emergency services

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw evidence that patients were assessed and their medical needs identified quickly so they could be streamlined to the correct area. Patients National Early Warning Scores (NEWS2) or Paediatric Early Warning Scores (PEWS) were assessed and updated.

Clinical pathways were adhered to and inclusion those for sepsis where suitable and pain levels were assessed and acted upon.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff we spoke to were able to demonstrate a knowledge of the act and the correct use of the powers.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Where appropriate patients were referred for support from the onsite Mental Health Liaison Team.

Patients assessed as needing support from a physical or occupational therapist were able to be assessed in the department.

The department also had access to support from drug or alcohol services for patients in need of referral following discharge from the U&E department.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients and their families who we spoke to had been offered food and drink. Food and drink rounds took place and were organised by a volunteer service. Food and drink options were available in the children's department for their needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Our review of patients notes showed that fluid balance assessments took place when appropriate for adults and children.

Urgent and emergency services

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We looked at a sample of patient records for both adults and children, we saw that patient's pain had been assessed and recorded appropriately. Patients we spoke to confirmed that they had been asked about their pain and medication needs. Patients received pain relief soon after it was identified they needed it, or they requested it.

The trust provided audit data following our inspection which showed that where appropriate 100% of patients both adult and children had been assessed for pain relief at triage for the period from 1 February to 31 May 2023.

The trust had also taken part in the 2022 Royal College of Emergency Medicine audit, in which a sample of 147 patient records had been reviewed and that with the exception of 1 record all had been assessed within 38 minutes of triage and that a nationally recognised pain assessment tool had been used and staff had prescribed, administered and recorded pain relief accurately. This audit was due be completed again in March 2023, the findings of this review were not available at the time of our inspection.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. They completed Royal College of Emergency Medicine audits on an annual basis. 'Pain in Children', 'Infection Prevention and Control' and 'Cycle Consultant sign off' audits had been completed in October 2022. The 'Pain in Children' audit findings led to actions to increase staff awareness within emergency medicine nursing and medical teams, such as circulating information on the audit outcomes and how to improve the administering and assessing of pain relief for patients, a review of the scanning of drugs charts and a poster in waiting rooms for families and carers to remind staff to reassess pain scores.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

The service had a lower than expected rate of re-attendance than the England average. Re-attendance within 7 days from October 2022 to March 2023 was between 6 and 6.1%; England average for November 2022 was 9%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. Audit results were shared with staff on a monthly basis and discussed by the managers within governance meetings.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Urgent and emergency services

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The children's U&E had paediatric trained staff and Emergency Severity Index trained nurses. Nursing and medical staff working in the adult U&E department were also trained in Advance Paediatric Life Support Training (APLS) and European Paediatric Advanced Life Support Training (EPALS).

Managers made sure staff received any specialist training for their role. The trust provided life support training for nursing and medical staff. The level of training was dependent on the banding or level of the staff. The courses were: Advanced Life Support training (ALS), APLS, EPALS, Intermediate Life Support training (ILS) and Paediatric Intermediate Life Support training (PILS).

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke to told us they had received a full induction tailored to their roles and that this induction had been thorough and they had felt supported.

Managers at the service told us they supported staff to develop through yearly, constructive appraisals of their work. Evidence provided to us at the time of our inspection showed that the appraisal rate for U&E nursing staff was13.2%, the rate for children's U&E nursing staff was 0%, and minors U&E nursing staff was 70%. Medical staff in the U&E had a 97.72% appraisal completion rate. However, further evidence we received following our inspection showed that the rates of appraisal completion where overall 96.1% for nursing staff.

Managers mostly supported nursing staff to develop through regular, constructive clinical supervision of their work. However, the service acknowledged that the turnover and retention of paediatric nursing staff was due largely to the lack of development opportunities and that this was on the trust risk register and being reviewed regularly with actions in place to improve the retention and recruitment for this staff group.

Nursing staff in the adults U&E and children's U&E completed competency booklets which covered areas such as safeguarding and how to access local teams for support, assessing patients for sepsis, monitoring NEWS2 or PEWS, treating burns and injuries and other procedures. These booklets were signed by the member of nursing staff and an assessor to confirm they as competent for the role.

There were 45 registered nurses in adult U&E department of which 35 were recent graduates and still completing the competency document. In total, 71% of the nursing staff had completed the competency booklet.

We also saw that 8 of the 10 registered paediatric nurses had completed the competency booklet.

The clinical educators supported the learning and development needs of staff. Staff told us they were given opportunities for learning and that they had time on Wednesday mornings to review department 'learning nuggets' provided by one of the lead consultants.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they were able to attend training sessions and could either book time during their working day for this or complete training in their own time and request the time off in lieu.

Staff in the children's U&E department told us they had support from the medical staff in the adult U&E department and that if a consultant was needed to assess a patient, one would attend the department promptly.

Urgent and emergency services

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The trust held regular meetings with other services, such as the local mental health team and local authority to discuss patient access to other services.

Staff worked across health care disciplines and with other agencies when required to care for patients. The ambulance service provided a Hospital Ambulance Liaison Officer (HALO) daily, the role of this officer being to help the ambulance service anticipate patient arrivals, monitor patient access and flow and inform the trust of any potential waiting time breaches or capacity issues in the department which would cause a delay in the offload and triage of patients. The ambulance staff we spoke to stated they felt they had a good working relationship with the staff in the department and that they worked together to find solutions to potential patient safety issues.

Staff we spoke to in the U&E departments told us that the response times from other departments within the trust were good and that referrals were acted upon quickly and effectively.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We observed the mental health team attending the department following a referral and assessing a patient's needs and discussing follow up actions for the patient to be access support following discharge.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. X-ray emergencies and inpatients were completed 24/7 as clinical need dictated. Routine requests were done at Russells Hall Hospital only and appointments were offered from 9am to 5pm, Monday to Friday. If there was a planned outpatient's clinic outside of these times or at the Guest outpatients or Corbett Hospital, then the department would be staffed, and x-ray would be available accordingly.

The pharmacy could dispense drugs for patients to take home from their drug charts from 9am to 7pm, Monday to Friday and 9.30am to 5pm at weekends.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Leaflets were available in patient waiting areas giving information on mental health support, cancer services, accessing support for drug or alcohol use and also other services provided within the local area.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Urgent and emergency services

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Staff could explain the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew how to access the policy and get advice on applying the Mental Capacity Act and Deprivation of Liberty Safeguards. Clinical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, the completion rate was 75% and did not meet the trust target.

Staff could contact an onsite mental health liaison team for support and advice.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

During our inspection we observed the Mental Capacity Act huddle which was a consultant lead meeting, topics discussed were the importance of correct and timely completion of paperwork, use of the assessment tool online and shared learning.

The department had 4 bays which were 'ligature light' and where possible were used for patients who attended the urgent and emergency care (U&E) department with mental health concerns. The cubicles had removable patient monitors, oxygen and suction fixtures, and curtains were held in place with magnetic anti-ligature rails. The cubicles were in clear sight of staff workstations.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patient dignity was maintained as each cubicle had a curtain and we did not observe any corridor care at the time of our inspection.

Patients said staff treated them well and with kindness. We observed staff interacting with patients in a kind and compassionate manner. We saw 2 patients in the resuscitation area who were distressed, and staff interactions were calm and reassuring.

Staff followed policy to keep patient care and treatment confidential. Patient files and medical records were stored securely on a password protected electronic system.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Patients' needs were discussed at the morning huddle meeting in an unbiased manner and with care.

Patients and their families could give feedback on their experience of the department and the care they received. Posters in the department and reception areas explained they ways of providing feedback. The service received an average of 700 responses to the patient survey each month which was approximately 19% of the patients eligible to respond. The service scores were between 70% and 73% good or very good which was above the national average and 13% to 20% poor or very poor. The trust website had a 'you said, we did area' detailing the most common complaints and themes from patient feedback, for example 'waiting times for medications were too long' and the trust has responded with 'we have installed a tracking system in the pharmacy waiting room to show patients their position in the queue'.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The department had a relative's rooms which provided some space and privacy for families when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed compassionate care being given to distressed patients and their families.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff were offered training in breaking bad news and end of life care, in the department 100% of medical staff and 82% of nursing staff had completed this training, this is not mandatory training and therefore the trust does not have a compliance figure.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients and their families that we spoke to said they felt they had been kept informed about their care and any ongoing treatment needs.

Staff talked to patients in a way they could understand, using communication aids where necessary. We saw that pain score tools were available to allow staff to communicate with patients. The service also had a list of staff who were able to communicate in other languages in instances were translation services were not available.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Posters in the department and reception areas explained they ways of providing feedback.

When required staff supported patients to make advanced decisions or informed decisions about their care. We saw that were appropriate Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were being used for patients to be able to communicate their treatment and care wishes.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service mostly planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

However, not all facilities and premises were appropriate for the services being delivered. The resuscitation area of the department had 4 bays which staff told us would often be fully utilised and 1 of these bays was intended for paediatric patients who would be taken to an alternate resuscitation room if this bay was in use.

The children's U&E department was in a separate area. This department was clean and bright with age-appropriate decorations. There were toys and books available for younger children to play with and there was a separate games room for which had been designed especially for older children.

The service had systems to help care for patients in need of additional support or specialist intervention. There were therapists situated within the department for patient support, such as occupational and physiotherapists.

The service had a GP onsite daily where patients who attended with non-urgent medical conditions could be seen by.

The managers met monthly to discuss pathways in and out of the department. The service had a standard operating procedure for the management of an increase in attendances and to reduce patient delays. The policy outlined action to be taken and the pressure points within the system. This policy had been reviewed and was in date.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. There was a mental health team situated on site who could be contacted to attend the department for assessments. A separate room was available for patients who were living with mental health problems and wanted a quiet, private area to sit. The room was bright and clean, free from clutter and had 2 exits and was in view of the nurse station.

Urgent and emergency services

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had lead nurses for patients with learning disabilities and dementia. Staff were able to tell us who these nurses were and how they would contact them.

The service had information leaflets available in languages spoken by the patients and local community. Patients could access leaflets using a barcode (or QR code) which they scanned to their mobile phone or device, the leaflet was then downloaded for them to be able to access later or when needed. These leaflets were available in languages other than English. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was access to interpreters via a language line, but also available was a list of staff who spoke other languages. Staff told us this list was useful and easy to access.

Access and flow

People could mostly access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, the service recorded that the ambulance offload times did not meet the trust target of 95% within 15 minutes.

Managers monitored waiting times and mostly made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Patients who arrived at the department on an ambulance remained in the care of the ambulance service until handover to the urgent and emergency care (U&E) department was complete. However, all staff were clear that the hospital had clinical responsibility for these patients.

The service had Hospital Ambulance Liaison Officer's (HALO's) who was based at the ambulance entrance situated within the U&E department. The HALO's role is to work with the ambulance crew staff and the department staff to reduce the ambulance waiting times at the department and to help ensure that those patients with the most serious presenting conditions are prioritised.

The service had a target that all attendances for patients arriving by ambulance would be triaged within 15 minutes of arrival. The percentage of ambulance admissions achieving the 15 minute triage target was on average 98% (February 2023), 98% (March 2023) and 99% (April 2023), meeting the trust target of 95%.

However, the service recorded that the ambulance offload times did not meet the trust target of 95% within 15 minutes. This was reported as being consistently low and on average was 25% (February 2023), 25% (March 2023) and 20% (April 2023). The lowest weeks were 26 March 2023 which was 19% and 16 April 2023 which the service reported offloads were achieved within the trust target only 12% of the time. Patient offload delays have a detrimental impact on patient care on the frontline and increases the risk of deterioration in patients at home in need of urgent care.

The percentage of self presenting adults' major's admissions achieving the 15 minute triage target was 49% (February 2023), 46% (March 2023) and 65% (April 2023), this did not meet the trust target of 95%.

The percentage of self presenting adults' minor's admissions achieving the 15 minute triage target was 64% (February 2023), 70% (March 2023) and 72% (April 2023); this did not meet the trust target of 100% but showed an improving picture.

The percentage of walk-in paediatric admissions achieving the 15 minute triage target was 73% (February 2023), 72% (March 2023) and 82% (April 2023); this did not meet the trust target of 95% but showed an improving picture.

Urgent and emergency services

The average time spent in the department (prior to admission) wait was 219 minutes (February 2023), 247 minutes (March 2023) and 203 minutes (April 2023), meeting the trust target of less than 240 minutes for February and March 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. The department was organised and managers knew which patients were being seen and for which condition. We observed staff safety huddles where roles and patients were allocated to staff, capacity issues were also discussed at these huddles and concerns escalated to site management where necessary. The site management team organised capacity meetings twice a day.

A weekly Emergency Department Assurance report was compiled for managers and the executive team. The report detailed the overall performance for the department that week, comparisons to previous weeks, triage performance and ambulance handover performance and comparisons to the Emergency Access Standard (EAS) which sets the standard that patients should be admitted, transferred or discharged within 4 hours of arrival. Where the EAS had not been met actions taken to improve or to mitigate risk to patients were detailed.

The number of patients leaving the service before being seen for treatments was low. Data received following the inspection showed 3.2% of patients between February and April 2023 left the department without being seen.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge notes were added to the Electronic Patient Record (EPR) and once all the necessary fields had been completed on the EPR a letter could be generated to the patients GP. If any of the fields on the EPR had not been completed correctly the administrator for the department would add this patient details back to the department tracker for completion. Referrals could be made to physiotherapists and occupational health therapists where necessary. Staff supported patients when they were referred or transferred between services.

The department also had an Emergency Department Escalation Process as part of the standard operating procedure. This process was to provide staff with a clear process for managing services at times of capacity compromises, to identify the process for the escalation of surge and capacity issues.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. There were details in all patient areas and on the trust website of how to make a complaint and how to make contact with the Patient Advice and Liaison Service.

Patients, relatives and carers knew how to complain or raise concerns. Data we saw following our inspection gave 2 examples where the service had received complaints and responded. The responses were within the service timeframe for responding and the concerns raised by the patient had been answered fully.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Managers we spoke to explained the complaints process and the common themes. These were discussed at staff meetings and learning shared in newsletters.

Urgent and emergency services

We also saw that managers reviewed comments and compliments, and these were also feedback to staff.

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.

There was a clear leadership team within the department, and it was well organised. Staff knew who the managers and divisional leader were and felt that they were visible. There was a senior Triumvirate with overall responsibility for the urgent and emergency care department and medicine division. This consisted of a Divisional Chief nurse, Chief of Medicine and Director of operations.

The local leadership team was comprised of a Matron, Directorate Manager, Deputy Directorate Manager and a Clinical Director.

Managers had the appropriate level of knowledge to run the department and they worked well together within the department to the benefit of the patients and staff. There was an Emergency Physician in Charge (EPIC) within the department, working with the Matron to provide clinical leadership for the adult urgent and emergency care (U&E) department.

The Matron in post was an interim Matron in place covering long term sickness in the department and had the support of a Deputy Matron. The Deputy Matron offered day to day clinical support to both the Matron and staff on the department. The trust told us following our inspection that they had plans to recruit 4 Deputy Matrons in May 2023 to work alongside the EPIC, medical staff and nursing staff and provide support during handover periods. The department had 17 Band 7 nurses working across both the adults U&E and children's U&E.

The children's U&E Lead Nurse worked with the U&E Matron and had the support of a consultant.

Managers were aware that staff in the children's U&E felt they had very few opportunities to develop professionally, and we were provided with evidence of plans to increase the staffing and offering opportunities to develop within the trust. Staff were offered opportunities to rotate to other disciplines or to be able to gain skills in leadership and develop into other roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Urgent and emergency services

The trust strategy was 'Shaping Our Future' with the vision of 'Excellent health care, improved health for all'. This strategy consisted of 5 goals:

- Deliver the right care every time
- To be a brilliant place to work and thrive
- Drive sustainability
- Build innovative partnerships in Dudley and beyond
- Improve health and well-being and reduce inequalities

The strategy planned to develop and review the clinical services and implement changes to the urgent and emergency care pathway 'to provide increased capacity to manage peaks in demand and improve flow through the hospital'.

Most staff we spoke to were aware of the strategy or the elements which impacted the U&E services.

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.

During the morning huddle we attended, staff were reminded to take breaks away from work to speak to managers if they had any concerns. We observed staff successes and compliments being discussed at meetings and saw feedback displayed in staffing areas.

We observed good working relationships within all levels of the staff in the department. Staff we spoke to told us they enjoyed working with the team and felt valued and supported. Staff said they felt able to discuss any concerns with their line managers and knew where to access support.

Nursing staff we spoke to said they felt the clinical leads were visible and supportive.

The service had access to 24-hour security and doors around the department were fitted with controls so only staff with a pass could access the area.

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.

Systems were in place to assess, monitor and improve care within the U&E department. The U&E team held weekly Governance Meetings and a weekly Emergency Department Assurance report was compiled for managers and the executive team. They also reviewed performance, staffing and audit outcomes. They investigated serious incidents and shared learning.

Mortality and morbidity meetings took place monthly involving senior medical staff and senior nurses. We saw the minutes from these meetings, and they discussed audit outcomes, specific cases were presented, and learning outcomes discussed. We were also told there were weekly consultant meetings.

Regular audits were conducted to assess the quality of care and any areas for improvements. We saw details of action plans from audits and time specific completion dates. We also saw audits completed with the Royal College of Emergency Medicine these included: 'Pain in Children', 'Infection Prevention and Control' and 'Cycle Consultant Sign Off'. The findings from these audits were shared with the U&E team and wider teams. These meetings and outcomes also fed into the trust Risk Register and there was a clear action to be taken, updates and deadlines.

During the operational meeting we attended managers discussed appraisal completion rates, completion of mandatory training, staffing levels for all disciplines, performance of the service improvement plans for the Resuscitation area and also celebrated successes within the department.

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.

Leaders had oversight of the performance in the department and were able to provide data to show how they monitored and took action to improve performance where required.

The department had a risk register, the 3 highest risks were:

- 50% vacancy rate at Band 5 in urgent and emergency care department
- Critical shortage of urgent and emergency care middle grade doctors
- Multi-agency referral forms not being uploaded electronically to system could result in patient harm

The risks had actions and completions dates associated allocated and also the member of staff responsible for the monitoring of the status or change in risk.

Mortality and morbidity meetings took place monthly involving senior medical staff and senior nurses. We saw the minutes from these meetings, and they discussed audit outcomes, specific cases were presented, and learning outcomes discussed. If a concern was found, a comprehensive investigation was completed and reported to the relevant external organisations.

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.

The service used a computer based IT system and made good use of the data available to them. For example, consultants could access alerts for deteriorating patients and information they would need, such as NEWS2. We saw that staff used electronic devices confidently for assessing patients, accessing information, and making referrals for patient support either within the trust to other departments or to external agencies.

Leaders showed us data gathered from audits on the IT system and how they could access the detail of the audit, outcomes and actions to be taken.

Urgent and emergency services

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 completed a survey on an annual basis which asked for feedback on areas such as the job role, the team, the organisation as a whole, managers, health and wellbeing at work and personal development. The trust scored highly on areas such as staff feeling trusted to do their job, feeling their role made a difference to patients and staff never having experienced violence from a member of the public or other members of staff. However, the trust did not score very well on staff feeling involved in changes that affect the way they work, having enough staff to be able to do job and time pressures being realistic. Managers we spoke to told us that as a result of the staff survey initial planning had taken place and areas of focus had been identified.

Patient feedback was gathered by the department and reviewed by managers. The service received an average of 700 responses to the survey each month which was approximately 19% of the patients eligible to respond. The service scores were between 70% and 73% good or very good which is above the national average and 13% to 20% poor or very poor. The trust website had a 'you said, we did area' detailing the most common complaints and themes from patient feedback, for example 'waiting times for medications were too long' and the trust had responded with 'we have installed a tracking system in the pharmacy waiting room to show patients their position in the queue'. Leaders showed us responses to patient surveys and there was a good level of responses and action to improve the outcome had been discussed at meetings.

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 had developed a paediatric head injury discharge process which was nurse led, this was to help facilitate assessment and discharge of minor head injuries at triage for children presenting to the U&E department. The process was put in place to reduce waiting times, facilitate the fast turnover of patients, decongest the department, and improve the patient's journey when the child presents with a minor head injury that can safely be discharged at triage meeting certain criteria. The service had a standard operating procedure for this process and certain criteria that needed to be met and also an exclusion criterion for certain injuries for example, but not limited to, where the child has lost consciousness, had problems with their balance or walking, there was suspicion of and non-accidental injury, possible ingestion of a foreign body. Children with learning difficulties were also in the exclusion criteria. The inspection team noted that this was an innovative process and was well embedded within the paediatrics team. The paediatric head injury discharge process was consultant led and all the nurses within the children's U&E department would be given the training. At the time of our inspection 6 out of the 8 triage nurses in the department had been trained on the new process. Staff we spoke to reported this procedure worked well.

One member of the consultant team had developed a web based application to be used on mobile phones and tablets by all staff whilst in the U&E department. The application was mentioned to us by most staff we spoke to, the application had a tab for all of the consultant on call, escalation phone numbers and contacts for the safeguarding team and other support teams. There was a list of staff who were bi-lingual and the languages they could support patients with for interpretation. Mandatory training deadlines could be accessed via the application and sickness and

annual leave could be added and monitored. Staff told us one of the benefits of the application was the weekly learning nuggets, each week on a Wednesday any learning from incidents or updated training could be accessed on the application, this made it easier to access if needed during working time if advice needed for a particular patient, such as for head injuries.

Areas for improvement

Urgent and Emergency Care:

MUSTS:

- The trust must ensure they continue their work to improve ambulance handovers and patient flow within the department (Regulation (17)(1).

SHOULDS:

- The trust should ensure that all staff are up to date with their mandatory training (Regulation 12).
- Managers should ensure that services are planned to meet the needs of local people with regard to the resuscitation area (Regulation 17).
- The trust should ensure family discussions with children are consistently recorded and discussed (Regulation 17).
- The trust should ensure they improve their performance in relation to their deteriorating patient pathway measures. (Regulation (12)(1)).

Services for children and young people

Good ↑

The paediatric and neonatal clinical unit is based at Russells Hall Hospital and consists of 3 separate areas:

- Neonatal unit
- Paediatric ward
- Paediatric outpatients

Paediatric ward (C2).

At the time of our inspection there were 23 inpatient beds which accommodated acute medical patients including children and young people with mental health conditions.

There were 4 elective day care beds which were utilised Monday to Friday for elective case activity, such as surgical procedures and magnetic resonance imaging lists. There were also 3 funded high dependency unit spaces where level 1 care was delivered, and a children's outpatients department. The paediatric unit treated babies and children up to the age of 16 years old.

Neonatal unit

There was a level 2 neonatal unit for high dependency babies who required short term intensive care support following apnoeic attacks, continuous positive airway pressure (CPAP) and parenteral nutrition (tube feeding).

The neonatal unit had 3 neonatal intensive care, 2 high dependency and 13 special care cots. There were also 3 cubicles for babies requiring isolation.

The neonatal unit had 2 flats with kitchen facilities where parents were offered the opportunity to be resident prior to discharge to care for their baby independently with advice and support from the neonatal team.

Children's outpatients

The children's outpatients department provided clinics for general paediatrics, neonatology, diabetes, respiratory, neurodevelopment and emotional/behavioural clinics. There was also a dedicated assessment unit and nursery with therapists based in the unit.

We carried out a short noticed unannounced full comprehensive inspection of the Children and Young People's service on the 7 and 8 June 2023.

During the inspection, we looked at all 5 key line of enquiry which were safe, effective, caring, responsive and well-led.

We rated it as good because:

- 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 and acted on them. The service managed safety incidents well and learned lessons from them.

Services for children and young people

- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.
- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback.
- 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 mostly 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:

- Patient records including a mental health risk assessments for a young person at risk were not always accurate or fully complete.
- The service did not have enough staff with the recommended qualifications. However, there was an appropriate plan in place to achieve this.
- Performance in relation to the service's deteriorating patient pathway measures required improvement. However, the trust had been proactive in its implementation around a new dashboard that had identified this.
- Resuscitation training compliance was low.
- Medicine charts were not always completed correctly.
- Staff had not completed the Oliver McGowan training or the equivalent .
- Some areas were untidy and cluttered with limited space.
- Appraisal rates were low in some areas.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most people had completed it. However, training in relation to resuscitation was low.

Services for children and young people

The mandatory training was comprehensive and met the needs of children, young people, and staff. There was a comprehensive mandatory training programme in place. Modules included manual handling, infection control, neonatal resuscitation and safeguarding amongst other topics.

Nursing and medical staff received and mostly kept up-to-date with their mandatory training. Overall mandatory training performance was 92% which was above the trust target rate of 90%. However, individual module training figures were very low for adult resuscitation (33%) and low for paediatric resuscitation (73%). There was a paediatric resuscitation improvement plan in place; this included improving compliance to 98% by July 2023. There was also a neonatal unit paediatric resuscitation improvement plan in place with an imminent compliance rate of 86%. A workforce standardised training plan had also been devised for mandatory resuscitation training updates.

Ten out of the required 11 band 6 nurses/the shift leads were trained in European Paediatric Advanced Life Support with a 91% compliance rate. There was 1 staff member remaining who had been booked on for a resit.

Sepsis was included in training modules including resuscitation and intravenous therapy (IV) training. All consultants and registrars were compliant with their advanced paediatric life support course and newborn life support course.

Clinical staff completed training on recognising and responding to children and young people with mental health needs and autism. Most staff groups had completed training, such as autism awareness and mental health law. However, staff had not yet completed the Oliver McGowan training or similar.

The trust was in discussion regarding the Oliver McGowan training; the lead nurse for learning disabilities and the head of learning and organisational development were considering the most appropriate way, to ensure the training was provided across the trust. There was some learning element to the training which some staff had undertaken but this had not yet been established.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received email alerts around training with priorities, completion, and expiry dates. Any member of staff whose training was due to expire in the next 3 months or whose training had already expired received a personalised email with their training status flag.

Training compliance was monitored through monthly key performance indicators reporting and by divisional/team leaders. There were specific dashboards to support this including 1 on resuscitation and safeguarding adults and children. Persistent non-compliance was escalated to divisional operational teams to follow up. Additionally, the departments rota co-ordinator sent personalised email reminders to each member of the medical staff.

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. Safeguarding training target rates were met for safeguarding adults' level 1 and level 3; compliance rates for level 2 adults safeguarding staff groups ranged from 70% to 100%.

Services for children and young people

100% of staff had completed safeguarding children level 1. However, some staff groups were below the 90% target for children's safeguarding level 2 and level 3 with figures ranging from 79% to 100%. Safeguarding children's training level 2 and 3 covered information about child sexual exploitation.

All paediatric consultants were up to date with their level 3 safeguarding children training and had child protection experience and skills.

Level 4 safeguarding children's training had been completed by the named doctor, named nurse for children, lead nurse for safeguarding children, the head of safeguarding, the named midwife, and the lead nurse for child mortality.

Staff knew how to identify children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff worked with other agencies, such as the local authority when safeguarding concerns were identified and this was documented in patient records.

There were up to date safeguarding policies in place including a safeguarding children policy, a child protection medical examination policy and a safeguarding supervision policy. Additionally, there was a child sexual exploitation resource pack available to staff.

Safeguarding policies contained links to relevant legislation such as the Children Act 1989, Safeguarding Children and Young People and the Roles and Competencies for Healthcare Staff (Royal College of Nursing 2019). There were restrictive interventions for children and young people guidelines in place. The guidelines included a section on the use of sedation, restraint, and the prescribing of rapid tranquillisation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of how to make a safeguarding referral and were able to give examples of safeguarding and escalation. Staff completed multi agency referral forms for the local authority when required.

During the inspection we found that although there had been interactions between the hospital safeguarding team and local agencies some safeguarding concerns had not been picked up from the electronic system or shared on the transfer sheet from the emergency department, therefore the concerns had not been shared with staff at a safety huddle. We raised this with the trust during the inspection; as a result, leaders sent out communications to the emergency department to ensure that concise and correct handovers were given. A discussion of the case was also tabled for the next paediatric pathways meeting to ensure learning was shared.

The hospital safeguarding team worked closely with the children and young people's services. This included providing safeguarding supervision to clinical staff. The safeguarding supervision policy contained a safeguarding supervision matrix detailing the level of support and frequency required.

We reviewed a safety huddle record from a joint children and young people services and children's emergency department and noted a safeguarding incident that had needed escalation had been discussed.

Staff checked child protection information sharing systems and completed child sexual exploitation tools when required. Safeguarding link nurses were available to offer safeguarding support and the trust's named nurse for safeguarding children attended the children's ward daily and also attended huddles.

A pregnancy testing prior to surgery guideline (ages 12 to 18 years) was available. The aim of the guideline was to provide guidance to protect children aged 12 to 18 years that were at risk of undergoing surgery or radiological investigations when pregnant, and to help identify actual or potential sexual exploitation. The guideline referenced relevant guidance and legislation.

If a child or young person was assessed to be at risk of suicide or self-harm, arrangements to keep them safe included risk assessments, intentional rounding, bedside checklists to check belongings and support from the Child and Adolescent Mental Health Services (CAHMS) team.

Staff followed safe procedures for children visiting the ward. There was a buzzer entry/swipe access system in place to allow entry into the children's and neonatal ward. We visited the children's outpatient's department and were asked by staff to show our identification.

There was a chaperone policy in place. The policy was in date and version controlled and referenced other relevant materials and guidance around chaperones. We saw evidence a chaperone had been offered and recorded in an admission document.

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.

Ward areas were clean and had suitable furnishings which were clean and well maintained. All areas we visited were visibly clean. Disposable curtains were dated to show when they had last been changed.

Cleaning tasks were completed under a private finance initiative. The neonatal ward also had a housekeeper from Monday to Friday between 9am and 3pm.

Posters displayed information around infection prevention and control. There was a commitment to cleanliness charter on display which contained cleaning tasks and frequency. The neonatal unit displayed a 5-star cleanliness rating in relation to an audit that took place on the 5 June 2023.

At the time of the inspection the infection control team visited the neonatal ward to complete weekly audits. The team completed bespoke training, reviewed protocols and used real life examples to train staff; they also completed a weekly walkaround and action log. The team spoke of leaders issuing individual staff with letters when an important message needed to be relayed.

The infection control team formed part of the in-service training days for staff, where bespoke sessions relating to infection control were delivered; for example, the team spoke of sessions on single use items, donning and doffing, blood gas protocols in which they used real life examples and talked through actions. PowerPoint slides of the sessions were sent to all staff and staff needed to sign to say they read and understood the information. There were infection control link nurses in place.

We reviewed the notes from a safety huddle that took place in June 2023 and noted that infection control was a standard agenda item.

The service generally performed well for cleanliness. The neonatal unit had been assessed in October 2022. The unit scored 100% for cleanliness, privacy, condition and disability.

Cleaning records were not always up to date to demonstrate that all areas were cleaned regularly. There were gaps in the recording on the daily cotside cleaning checklist on the neonatal ward. Staff told us that this was likely as the cots were not in use at the time; however, staff had not recorded this.

Leaders were in the process of implementing a new recording system in relation to deep cleans, but used 'I am clean' stickers. Care support workers completed daily checklists, such as ensuring the milk kitchen was clean and tidying trolleys.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore personal protective equipment as required. Parents told us and we observed that staff washed their hands regularly.

We reviewed the results of the hand hygiene 5 moments audit for the children's ward C2 and saw compliance for the last 3 periods was between 96% and 100% which met the trust target of 95%.

Neonatal hand hygiene 5 moments audits for the last 6 months showed compliance rates of 100%, however no results were available for 2 of the 6 months.

There were infection prevention and control clinical practice audits in place for the neonatal unit. Actions included adding the drugs trolley to the cleaning schedule and ensuring sharps containers were closed. Action plans were also in place for the children's outpatient department with actions including completing a patient group directive audit.

The paediatric outpatient department completed a hand hygiene 5 moments audit and had achieved a consistent 100%, apart from the most recent audit when results were not available.

There were various infection prevention and control procedures in place. These included a cleaning and disinfection of the environment policy, a decontamination of body fluid spillages standard operating procedure and a standard infection control precaution, hand hygiene and PPE policy.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. I am clean stickers were displayed to show the date equipment had been cleaned. For example, we saw these had been placed on the chairs in the children's outpatient department.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe; however, space and facilities had been identified as insufficient to allow compliance to required standards in the neonatal unit and some areas on the children's ward were cluttered. Staff managed clinical waste well.

Children, young people and their families could reach call bells and staff responded quickly when called. Parents told us staff attended to them quickly if they needed anything.

The design of the environment followed national guidance. The environment was safe for the age of the child. For example, we saw when appropriate, doors were kept locked and toilet door handles/locks were out of young children's reach in the children's outpatient department.

Staff carried out daily safety checks of specialist equipment. When 2 gaps in daily checks were identified, we noted it was reported on the trust's incident reporting system. Specialist equipment for all age ranges, including that required for resuscitation, was available and fit for purpose.

Services for children and young people

There was no defibrillator on the resuscitation trolley in the children's outpatient's department. However, instructions were in place to attend the nearest unit in maternity which was a short distance away.

There was a lack of space on the children's ward. We visited a bay in the children's ward and found the area was cluttered and untidy and that the cubicle was also being used for some storage and that oxygen masks were tangled; this could be an issue if the mask was needed quickly. We raised this at the time of the inspection, and it was addressed immediately.

Space and facilities on the neonatal unit were identified on the risk register as insufficient to allow compliance with the required standards. Mitigations included positioning of equipment so it could be accessed safely, storage of some items off the unit and best use of space using storage racks and shelving. Actions in response to the risk included setting up a task and finish group, completion of a feasibility study and developing a standard operating procedure. The risk remained red on the register. However, there were plans for expansion of the neonatal unit. A plan had been produced and the service was working with estates to complete a final feasibility study.

There was a 2-bed recovery area for children post-surgery which was very child friendly. The day surgery recovery area was divided by a curtain in an adult area and was child friendly.

The children's outpatient department had suitable facilities for children and had toys, child friendly posters and mobiles.

The service had enough suitable equipment to help them to safely care for children and young people. Processes had been put into place to ensure there was enough stock in place and that stock in cupboards was organised and rotated effectively.

Leaders had ensured there were allocated staff members in place for ordering stock and that staff were aware to escalate to the nurse in charge if stock was running low. There was a daily checklist in place for restocking areas. There was an improvement team in place who were reviewing all stock rooms and stock was discussed daily. Staff told us how improvements had been made in this area.

We saw information on a board in the children's ward "The Way We Care" which had details of the weekly huddle topics and note this included the stockroom being decluttered and rearranged.

The neonatal unit had worked with the procurement department to review stock. Stock areas had been reviewed and divided into specific areas to ensure a more organised approach. A stock list had been formulated of all items to be listed in a catalogue. A catalogue was developed in a systematic order to facilitate a structured way for ordering. We saw that stock ordering was discussed in a huddle on the neonatal unit.

A whiteboard was in place for staff to communicate any issues relating to stores. Procurement staff were responsible for reviewing the whiteboard and updating the nurse in charge when they attended the ward. There was a put away procedure in place which included the method of unpacking and putting deliveries away in appropriate locations.

We reviewed the compliance of the last 6 environmental audits in the children's department (C2). Results showed compliance ranged between 82% and 96% with the last 4 audits showing improvement with results above 94%.

Compliance rates for the environmental audit on the neonatal unit ranged between 87% and 97%. The most recent audit showed improvement going from 87% to 97%.

Staff disposed of clinical waste safely. There were clinical waste bins in place, and they were emptied regularly. Waste storage rooms had key code access. There was a waste management policy in place.

Assessing and responding to patient risk

Staff mostly completed 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. However, audits completed by the trust around the deteriorating patient pathways showed improvement was required around senior clinician review and completion of escalation documents.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff completed paediatric early warning scores (PEWS), and observation charts in the neonatal unit were completed correctly.

The trust had implemented a deteriorating patient pathway (DPP) which was launched trust wide on the electronic patient record system in November 2022. The DPP was a live system for all leads, matrons and consultants to have oversight of their areas giving data that the trust had not previously been able to analyse or access.

Staff completed training on the digital deteriorating patient pathways. Once completed, staff needed to sign to say they had completed and understood the training. PEWS training was available to staff and compliance at the time of the inspection was 87%. There was a deteriorating patient policy in place.

There was a deteriorating patient pathway/sepsis dashboard for ward C2 and the paediatric assessment unit (PAU). The report dated June 2023 showed sepsis screening was 100% for completion within 1 hour.

We reviewed the deteriorating patient pathway performance update slides from February to May 2023. Results on the slides showed the escalation document had not been completed in 78 cases out of 115 on ward C2 and in 16 out of 44 cases on the PAU.

The deteriorating patient pathway slides also looked at if a senior clinical review had been completed. Results showed that 39 out of 115 had been completed on ward C2 and 5 out of 44 on the PAU. However, it was noted that in relation to the PAU figures this was potentially a data capture issue. Learning identified from the results was for nursing leadership to focus on ensuring all deteriorating patients have the escalation document completed.

There was an electronic observation monitoring dashboard in place. Results for ward C2 from 1 to 18 June 2023 showed the percentage of patients with a flowsheet was 74%. Results for compliance for observation on time showed that 60% of observations were completed on time. Results for the PAU within the same timescale showed 74% of patients had a flowsheet and compliance with observations on time was 73%.

The deteriorating patient pathway slides from February to May 2023 showed 40% missed sepsis screening in paediatrics excluding the emergency department. We reviewed more recent data from the deteriorating patient pathway/sepsis dashboard and found it showed improvement with 100% of sepsis screening having been completed within 1 hour.

During the 2 days of inspection, we reviewed 26 electronic records and noted deteriorating patients were recognised, sepsis screens were completed, and critical care was reviewed. We found 24 out of the 26 observations we reviewed had been completed within the specified time.

Services for children and young people

Staff mostly completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed neonatal intensive care charts which contained information such as respiration, position, ventilation, incubator temperate, blood glucose and humidity.

Patient notes contained risk assessments such as skin bundles for pressure ulcer prevention and nutrition. Patient care records included care plans such as care of a child with a fever and care of a child with sepsis.

There were checks to monitor clinical staff aseptic techniques. These checks detailed prompts for staff such as ensuring the patient was in the correct position, correct equipment available and used the appropriate aseptic technique.

Staff were aware of the escalation policy if a baby or child was to become unwell. There was a deteriorating patient policy in place. The policy included information in relation to sepsis, PEWS, clinical responses and response times for senior clinical review. There was a deteriorating patient pathway process was available for staff in the staff room.

We asked for details of how many occasions during the last month when there had not been at least 1 member of staff in the children and young people's services that was qualified in advanced paediatric life support. Leaders replied that with the number trained there is always a trained European Paediatric Advanced Life Support course nurse available and that this had been the case throughout the month of May 2023.

There was a draft PAU triage standard operating procedure in place. The aim of the procedure was to provide a clear process on how children were triaged when they attended the PAU. The procedure included information on trigger criteria for PEWS scores.

There was a PEWS standard operating procedure in place. The aim of the procedure was to standardise the approach to recording, monitoring, assessment and reporting of vital signs and observations of children. The procedure contained information such as escalation, inter departmental transfers and post operative observations.

There was a PAU clinical standard operating procedure in place. The discharge process was that a set of observations must be completed prior to children being discharged. We saw in records that PEWS had been completed at discharge. Staff we spoke with were aware of this process.

We reviewed a PEWS folder in the children's outpatient's department and found it contained emergency calculations and observational charts for all age groups. It also contained a paediatric and adult sepsis screening and sepsis 6 pathway tool.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a child or young person’s mental health. Staff contacted the children and adolescent mental health services (CAHMS) team when they required support for children with mental ill health and they had completed assessments. In most cases the CAHMS team saw the child in the emergency department (7 days a week) prior to admission to the children’s ward; this meant less children being admitted to the children’s ward inappropriately. Staff had access to a 24-hour mental health advice line which they told us they had utilised when they had concerns regarding a young person.

Staff arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide, however risk assessments were not always completed in full. Staff referred patients to ICAHMS (intensive CAHMS) who supported children who met certain criteria, such as ongoing suicidal thoughts. However, we noted a risk assessment of a child who was a risk to self or others had not been completed fully including the risk

assessment of the bed space which did not highlight specific risks, had gaps in recording and the overall plan had not been signed off. This meant risks were not always assessed and recorded thoroughly. We raised concerns around mental health risk assessments and gaps in record keeping with the trust at the time of the inspection. In response to our concerns, a new process was added to the daily safety huddle proforma to prevent this from occurring again.

The new process was that the shift lead would check that CAHMS patients had an initial risk assessment completed on admission and that it was reviewed daily alongside additional training for new starters. Auditing of compliance was to be incorporated with the weekly documentation audit. The trust had also been working alongside the digital working group to review paediatric specific templates and documents and a trajectory was in place for the digital working group. Additionally weekly documentation audits were commenced.

Staff shared key information to keep children, young people, and their families safe when handing over their care to others. On the neonatal unit, competencies were assessed with parents. For example, parents' competence around use of nasogastric tubes when children were ready to return home.

Shift changes and handovers included all necessary key information to keep children and young people safe. There was a paediatric emergency pathways daily huddle in place with terms of reference. Membership included consultant of the week for paediatrics, a consultant from emergency medicine, the nurse in charge of paediatrics and the nurse in charge of the paediatrics emergency department. The huddle took place twice daily. The purpose of the huddle was to facilitate patient experience, patient flow, patient safety and shared learning.

There were various other safety huddles including doctor huddles where key information was shared to keep children and young people safe. We observed 2 safety huddles and found information such as patient risk, admissions, safeguarding, incidents, complaints and staffing were discussed.

We also observed a medical handover and found it was well attended, there was healthy challenge, it was holistic, and staff asked questions. Doctors were aware of the patients they were caring for and any results. They also provided the team with education and rationales when needed.

Nurse staffing

The service did not always have enough nursing staff with the right qualifications, skills, training and experience. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service did not always have enough nursing staff to ensure staffing ratios were met. On the children's ward (C2) there were 22 long days in May 2023 when staffing met the Royal College of Nursing (RCN) ratios (71%). There were 6 long days in May 2023 (19%) when planned Royal College of Nursing staffing ratios were not met. There were 3 days when paperwork had not been completed (10%).

On ward C2 in May 2023 there were 17 long nights that met the RCN staffing ratios (55%). There were 8 long nights that did not meet the ratios (26%) and 6 nights that paperwork was not completed (19%).

When staffing ratios were not met, this was escalated and reported as an incident. Where possible other staff were utilised, such as the lead nurse, community team or clinical nurse specialist team, who were not included in ratios due to being supernumerary. At night where there were 6 nurses or less, the PAU became 1 patient in 1 patient out, rather than being open completely.

Services for children and young people

Staffing information regarding the neonatal unit from May 2023 showed that 86% of shifts were staffed to the British Association of Perinatal Medicine (BAPM) recommendations and 67% of shifts were staffed to toolkit. This showed improvement since May 2022 when 61% of shifts were staffed to BAPM recommendations and 56% of shifts were staffed to toolkit.

Leaders told us a staffing paper had been produced and presented to the Board and that the children's service would be completing a staffing review for the neonatal unit and children's ward. Additionally, a recruitment drive was already underway. The department was also looking at utilising additional workforce, such as nurse associates, to both support the staffing levels and provide staff with opportunities for growth and development.

Nursing staff on the neonatal unit did not meet BAPM standards in relation to Qualified in Specialty trained staff. The service did not have the 70% of Qualified in Specialty (QIS) trained staff to achieve the BAPM standard of 70% of the neonatal workforce being QIS trained. As of the end of April 2023, only 41% of the neonatal workforce had the training. However, there was a trajectory in place to achieve this by August 2024. The unit planned to support the learners by providing supernumerary time at least once a month and by providing shadowing opportunities. Staff completed additional training such as that of enteral feeding and nasogastric tubes and triage. We reviewed the neonatal compliance figures with this training the day of the inspection in the neonatal unit and saw compliance levels were 96% and above.

Neonatal staffing and QIS trained staff were incorporated on the departmental risk register. Mitigating actions had also been taken to ensure the safety of the unit. For example, a daily safety huddle was completed to review the staffing and acuity of the Neonatal unit. Leaders also utilised the use of community and advanced nurse practitioners.

The service had reducing vacancy rates. At the time of the inspection, on ward C2 there were 5.16 whole time equivalent (WTE) band 6 vacancies, 1.92 WTE permanent posts to cover leavers, 2.28 WTE to cover virtual ward secondments and 0.96 WTE to cover maternity leave. Vacancy rates in the neonatal unit consisted of 0.96 band 6 establishment and 4.9 WTE band 5 establishment. There were no band 4 vacancies.

The service had varied turnover rates. The turnover rate for ward C2 nursing staff was 3.8% in the past rolling 12 months, this equated to 1.6 WTE; there was no turnover in other staff groups.

The turnover rates for nursing staff on the neonatal unit was 8.8% in the past rolling 12 months. This equated to 3.3 WTE; there was no turnover in other staff groups.

The service did not meet its target for sickness rates. Ward C2 sickness rates were 6.35%, higher than the trust's target of 3.5%. In the past 12 months sickness absence ranged from 3.75% to 9.97%. All sickness absence was being monitored as per the trust's policy.

The neonatal unit sickness rates were 5.42% which was above the trusts target of 3.5%. In the past 12 months sickness absence ranged from 2.4% to 7.27%

The service had high rates of bank and agency nurses. Information for ward C2 showed that in May 2023, 116 bank shifts were filled, and 79 shifts remained unfilled. On the neonatal unit 77 bank shifts were filled, and 30 shifts remained unfilled. Agency staff had been phased out following the trust's internationally recruited nurse recruitment drive.

Services for children and young people

In May 2023, 83.1% of bank shifts were filled by paediatric nurses, the further 16.9% were filled by substantive internationally recruited nurses who had completed the paediatric objective structured clinical examination (OSCE) and paediatric competency.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. Leaders reviewed and monitored staffing on a weekly basis and made any changes when needed to ensure the correct staffing. Tools, such as the neonatal nursing workforce, tool were used.

Safety huddles took place daily where staffing for all areas was reviewed and discussed. Additionally, the children's ward community outreach team and clinical nurse specialist team were also able to provide additional support when needed. Ward C2 operated on a minimum of 2 children's nurses on duty. A band 6 shift lead was always available.

Leaders on the neonatal unit told us that at the time of the inspection due to lack of QIS trained staff each shift was staffed with 2 QIS trained staff as a minimum. If additional nursing staff were needed, the neonatal community outreach team were able to offer support and had QIS trained staff.

Managers made sure all bank and agency staff had a full induction and understood the service.

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.

The service had enough medical staff to keep children and young people safe. Shifts were covered with a mix of staff including tier 1 doctors, tier 2 doctors and consultants. Safe staffing levels were set for medical cover in line with national guidance, for example saving babies lives bundle which sets out there should be a dedicated tier 2 doctor for level 2 neonatal units.

Overnight to cover paediatric and the neonatal unit there were 2 registrars, 2 senior house officers and a non-resident consultant. An electronic platform was in place to capture the medical rotas and keep track of any additional shifts to ensure excessive hours were not worked. For deanery and trust grade doctors they did not exceed 48 hours per week as per working time directive unless they had opted out. Doctors who were part of the medical training initiative were not able to work more than 20 additional hours per week.

Locum doctors had their curriculum vitae vetted by departmental medical service heads to ensure they had the full paediatric and neonatal qualifications and up to date/appropriate level of life support training. Longer-term locums had IT training and joined departmental teaching and training.

There was an immediately available dedicated resident tier 2 practitioner separate from paediatrics 24/7. Leaders had also decided to have a dedicated tier 3 rota to the neonatal unit entirely separate from the paediatric department.

There were 2 medical handovers every 24 hours. These were led by consultant paediatricians and took place at 9am and 4.30pm.

Services for children and young people

Consultant job plans were flexed in summer and winter due to an increase in demand through the winter period (October to March). In the summer months the consultant remained on site on weekdays until 6pm and in the winter the on-call consultant remained on site until 9pm. At the weekend the consultants remained on site from 9am to 4pm in the winter and from 9am to 2pm in the summer, however, during times of high demand the consultants would remain on site to support.

The process was that all children received a minimum of a registrar review prior to discharge. Any child admitted to the ward from the PAU had a minimum of a consultant review prior to discharge.

Agency/Bank staff were used to ensure medical staff matched the planned numbers. We reviewed information from May 2023 and found bank and agency staff were used to fill in any rota gaps for senior house officers, registrars and consultants. Throughout the month of May 2023 there were mostly safe staffing levels through utilising agency staff, with 2 occasions when medical cover gaps were identified.

The service monitored turnover rates for medical staff. Medical turnover rates were on a 12-month rolling figure and were 57% as of March 2023, most of which were fixed term contracts, such as trainees.

Sickness rates for medical staff were reducing. Absence rates were 4% in May 2023, this had reduced from 6% In April 2023.

The service always had a consultant on call during evenings and weekends. 24-hour consultant cover for the PAU was available via the on-call system. At the time of the inspection, the department was working towards a split paediatric /neonatal rota to help increase the availability of any cover. There was a consultant of the week system in place.

Specialist paediatricians were accessible to the trust 24 hours a day via direct calls to other local hospitals. There was also 24 hour a day support from other specialist services.

Records

Staff did not always keep detailed records including that of children and young people's care and treatment. Records were stored securely and easily available to all staff providing care.

Patient notes were not always fully completed; however, all staff could access them easily. We found gaps in record keeping was a consistent theme within patient notes. For example, we saw missing information, gaps and inconsistent documentation in patient records including risk assessments.

During the inspection leaders acted immediately when we raised that 2 fluid challenge charts had not been completed correctly. We returned to the ward the following day and reviewed a further fluid challenge chart and saw this was completed correctly. We saw leaders sent an email to all relevant staff showing the importance of this. Additional weekly fluid challenge audits were also implemented following the inspection with results to be shared via email, huddles and ward updates.

We raised concerns around poor record keeping with leaders at the time of the inspection who took immediate action to address our concerns. For example, following the inspection leaders increased the documentation audits to weekly from monthly and advised they would be reviewing audit results and feeding back to staff during daily huddles. Alongside this, leaders completed initial huddles and emailed staff to remind them of the importance of keeping concise records.

Services for children and young people

The documentation audit for the children's ward did not meet the trusts target of 95% over the last 6 months. Results ranged from 77% to 92% with the most recent audit compliance rate being 88%.

Documentation audit results for the neonatal unit ranged from 93% to 95%, however, there were no records available around compliance for the last 3 months.

Records were stored securely. Computers were password protected and patient notes were stored securely in locked cabinets. Staff were able to identify complex patients such as those with a learning disability or autism as there were systems in place to record this on electronic recording systems.

Medicines

The service mostly followed systems to safely prescribe, administer, record and store medicines.

Staff mostly followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed on paper medication charts. We looked at 10 medicine charts and found that allergies and weight were always documented to ensure medicines were prescribed safely and according to the child's weight.

Prescribers and nursing staff had access to resources to ensure medicines were prescribed at the correct dose. However, we saw on 2 charts that the maximum dose for a when required medicine was not recorded. This meant there was a risk that the patient could exceed the maximum recommended dose. On another chart we saw that a term used for quantity of a medicine had been abbreviated which could be misread. We highlighted this to the nursing team and pharmacist to ensure that this was corrected.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people and their carers about their medicines. Medicines were reviewed regularly on ward rounds. Clinical pharmacists regularly visited the wards, reviewed medicines and provided advice on dosing for medicines. For patients who were prescribed antimicrobials, there was a clear indication and rationale documented on the medicine's charts and in the clinical notes. Antimicrobials were reviewed at 48 to 72 hours as per trust policy.

Nursing staff spoke to parents and carers about their child's medicines on discharge to ensure they understood how to administer them. Contact details for the ward were also provided to parents and carers if they required further advice.

We spoke to 1 parent, who told us they understood what medicines their child was on and were informed when changes had been made.

Staff mostly completed medicines records accurately and kept them up-to-date. The paediatric ward used pre-packed medicines to facilitate rapid discharge. We reviewed records for 2 medicines and found that the stock count was not correct. Staff were not recording when they were transferring prepacked stock to use on the ward.

The trust had an audit programme to monitor the use of antimicrobials and safe storage of medicines. Issues identified were escalated to the ward matron for actions to be taken.

Staff stored and managed all medicines and prescribing documents safely. Medicines including controlled drugs, that is medicines requiring additional control due to the potential of misuse, were stored securely. However, we found an out-of-date medicine in the neonatal unit and paediatric outpatients. We raised this with staff, and they were removed immediately.

Room and fridge temperatures where medicines were stored were monitored and staff we spoke with understood when to escalate. However, in paediatric outpatients, the maximum room temperature had exceeded 25 degrees Celsius throughout June and July. We escalated this to leaders at the time who told us that the pharmacy was aware and that a solution was being worked on.

Blank prescriptions were stored securely, with a clear audit trail for when they were used in the paediatric outpatient department.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation, the process of accurately listing a patients' medicines they were taking at home and comparing it to what is prescribed whilst they are in hospital, was completed in a timely manner.

We saw 2 patients who had been discharged from the ward had not collected their discharge medicines, which included antibiotics. Staff were unaware why these had not been collected and told us that they did not routinely follow patients up who did not collect their medicines.

Staff learned from safety alerts and incidents to improve practice. There were clear processes to report and investigate medicines incidents when they took place. Learning from incidents took place though targeted teaching sessions with staff on the wards and in monthly ward meetings and mandatory quarterly ward meetings.

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. 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.

Staff knew what incidents to report and how to report them. Staff were able to share examples of incidents that had happened in the service. They told us they received feedback from incidents in a variety of ways such as in emails or in teams' groups.

The service had no never events on any wards. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Staff reported serious incidents clearly and in line with trust policy. Leaders had developed incident learning points when serious incidents had occurred. The learning points had information about the incident, areas of concern, good practice and outcomes and actions. The learning points were then shared with staff.

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. There was a duty of candour policy in place which was in date and version controlled. Leaders completed a duty of candour proforma following incidents which included a section on the patient/family/carer perception of events and any specific questions the patient /family wanted answering. We also saw the hospital had written to parents to advise of the investigation process and clarify/answer any questions they had raised.

Services for children and young people

Staff met to discuss the feedback and look at improvements to children and young people's care. Incidents were discussed in various meetings such as huddles, the paediatric and neonatal audit clinical governance meeting, consultant meetings, trust children's services group and unit meetings.

We reviewed the children's services governance report February 2022 to 2023 and March 2022 to March 2023. The report contained an overview of reported incidents such as the top 3 incident categories. The top 3 categories in February 2022 to 2023 were obstetrics, violence, aggression and self-harm and appointments, discharge and transfers. March 2023 showed the top 3 categories as being violence, aggression and self-harm, obstetrics and workforce.

We saw improvement huddle boards such as the 1 displayed in the outpatient's department which provided patients with information such as length of wait to first appointment, cost and referrals to paediatrics neuro disability delivery.

We looked at the review of neonatal deaths meeting minutes from April 2023 and May 2023. The meetings shared details of individual cases in detail, had notes on the multidisciplinary team discussions and actions identified during the review. Meetings were attended by a variety of staff including the saving babies lives lead midwife, lead sonographers, the matron and consultants. Learning from the meetings was shared as bite size learning, within the monthly children's services report and discussed within the children's services audit and governance meeting.

There was evidence that changes had been made as a result of feedback. There was 'you said we did' information on display. For example, patients had not received information about the unit facilities and parking. In response, all staff had been reminded to use the parent introduction to the unit checklist.

Managers investigated incidents thoroughly. We reviewed a root cause analysis report and saw it had been investigated and contained lessons learned, key recommendations and an action plan.

Staff spoke of having hot debriefs after a stressful event and how they also had a cold debrief later. A hot debrief is a process of bringing the team together to discuss clinical events immediately after an event; a cold debrief happens at a later date.

Managers took action in response to patient safety alerts within the deadline and monitored changes. We saw a patient safety alert audit of compliance with national patient safety alert Safer Practice Notification: Reducing the risk of low sodium levels in the blood (hyponataemia) when administering intravenous infusions to children had taken place. As a result, actions were identified and marked as complete such as encouraging more clinical staff to complete their medicines management and intravenous fluid training and to raise awareness. The bedside paediatric guideline was available on the trust hub.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good.

Services for children and young people

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were in date and version controlled. Policies included safeguarding, duty of candour, incident reporting, and infection control; they referenced relevant legislation and guidance.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. There was a standard operating procedure in place for detaining a patient under the Mental Health Act (1983). The procedure contained information for staff on completing paperwork, transferring patients between hospitals, discontinuing detention under the Mental Health Act and covered consent, the right to appeal and informing patients of their rights. There was a memorandum of understanding for the delivery of a mental health liaison service in place.

The service participated in accreditation schemes. The service had been awarded the Bliss baby charter bronze award for completing their second Bliss baby charter audit and working towards delivering high quality family-centred care. Bliss is a UK charity for babies born premature or sick, and champion the right for every baby born premature or sick to receive the best care.

The Bliss audit was divided into 7 principles including areas such as dignity and privacy, decision making, trained specialist staff and promoting and supporting breast milk expression. Areas rated as amber, that is delivering some or most of the aspects required to meet the criteria but not all, included; where families are offered psychological/ emotional support after receiving sensitive news, units have a clear criteria for assessing which babies require palliative care, taking into account diagnosis and prognosis and babies having time sensitive access to allied health professionals with specific neonatal or paediatric training.

We reviewed the UK Committee for UNICEF (UNICEF UK) BABY Friendly Initiative, Stage 2 assessment report Neonatal Service dated October 2022. The report found that the neonatal unit met some but not all of the standards for a stage 2 assessment to be passed. The report detailed how the neonatal unit could achieve and maintain the set standards for full accreditation. The areas that the service did not meet the standards included staff who were able to describe bottle feeding, staff who were able to recognise effective feeding and staff who were able to describe why it was important to avoid allowing advertising of formula milks in the health care system.

The children's services were in the planning stages for a 15 steps challenge for 16–18year-olds who accessed the services. Leaders had undertaken a 15 steps walk around with the Maternity and Neonatal Partnership. The purpose of the walk was to see the service through the eyes of women and their families. Ten patients or relatives had attended and observed all areas of neonates. Findings included that the transitional care area was a lovely environment, and they liked that women could be with their babies and that the area for dads (dad pad) was an excellent idea but required advertising. Areas for improvement included lack of storage space, area being cluttered and lots of colour and information on the walls made it hard to take in information. Ward C2 were seeking Makaton accreditation with 75% of its staff having already completed the training.

Services for children and young people

The service audited themselves against the National Institute for Health and Care Excellence (NICE) guidelines. Findings from the audit of updated NICE guideline for urinary tract infection in under 16s diagnosis and management, showed that the service was not hitting compliance they needed to improve diagnosis and management. For example, not using a clean catch collection, poor documentation and no information leaflets given. Recommendations from the audit included adding in a discharge sticker, teaching staff and a re-audit over a 6 month period.

We reviewed an audit on the use of sedation for day case procedures on the children's ward (April 2022). The audit concluded there was: -

- Good practice of assessment-pre and post observations.
- Medical conditions documented.
- Nil by mouth status documented.
- Weight and allergies documented.
- No patients had any adverse reaction to sedation.

Improvements included: -

- Educating staff on sedation risks.
- Sticker in patients notes to help doctors remember the risk of sedation.
- Arranging teaching sessions.

Staff completed an audit on the risk assessment and management of paediatric sepsis in September 2022. Recommendations included annual/biennial update of training for all clinical staff on sepsis screening and action tool, de-escalated alerts needed to be in a separate area of the dashboard, to make every effort to complete senior review in 30 minutes and to re audit in 12 months.

In addition to the above there were several other audits including an audit to assess effectiveness of nurse led bronchiolitis management and discharge pathway, audit of compliance with National Patient Safety Agency safer practice notification: reducing the risk of hyponatraemia when administering intravenous infusions in children, neonatal treatment sheet audit, golden hour audit and an audit on down's syndrome –initial management and follow up.

Compliance against NICE guidelines were monitored. Those still colour coded red (where improvement was needed) were in relation to asthma, looked after children and young people and diabetes type 1 and type 2 in children and young people: diagnosis and management. The service fully achieved compliance in 19 areas of guidance and partially achieved in 4.

The trust subscribed to 3 clinical decision-making tools which were available to staff on the trust hub or mobile device apps.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families.

Nutrition and hydration

Services for children and young people

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. There was a catering team in place who catered for any specific dietary or cultural needs; mealtimes were at 8am,12pm and 5pm. Care plans included information on special dietary needs, such as the management of patients on a ketogenic diet including treatment of low blood sugar (hypoglycaemia).

Patient notes contained information regarding feeding regimes and details of discussions held with parents around feeding.

Information, such as opening hours of places where parents could go to purchase food or drink, was displayed on notice boards. There were also kitchen areas for parents to make themselves refreshments and drinking water was available from water coolers.

Parent flats had a kitchenette, with a microwave, hot drink facilities and breakfast cereals. Mothers could access the food trolley from maternity if they needed a hot meal.

There was information for parents on breast massage techniques, milk ejection reflex and contact details of helpline numbers such as the national breast-feeding helpline and fathers and breastfeeding. We saw screens were available for privacy when breastfeeding. There was a parent information folder that contained information for parents on breastfeeding.

An expressing room was available for mothers who required somewhere to express their milk. The room had a milk storage fridge that was managed by staff.

There were enough feeding tubes in stock. Staff could access a feeding team and breastfeeding support was available if required.

Patient notes contained fluid balance charts and oral fluid challenges were in place when required, however, these had not been completed appropriately in 2 sets of records. Neonatal nutritional charts were in place, staff documented when a nasogastric tube change and feeding change were due. Donor milk records included dates, expiry and batch numbers, condition on arrival and storage condition. There was a fluid challenge standard operational procedure in place.

We reviewed a documentation audit from Ward C2 dated June 2023. The audit showed fluid balance was completed and totalled in 100% of cases over the last 6 months. In relation to food intake being fully recorded on the fluid balance chart the ward scored 100% in 4 out of 6 months, however the last months compliance was only 50%.

Specialist support from staff such as dietitians and speech and language therapists was available for children and young people who needed it. Staff told us they can bleep them when needed. Discharge plans when relevant included dietitian support.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Services for children and young people

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw a patients care plan included care of a child in pain and that staff used pain assessment tools such as the Face, Legs, Activity, Cry and Consolability (FLACC scale) and the Wong-Baker scale. The Wong-Baker scale uses a series of faces from 0 or no hurt to a crying face at 10.

Staff on the neonatal unit completed neonatal pain detection and management documents and used the neonatal infant pain score.

Staff mainly prescribed, administered and recorded pain relief accurately. We reviewed a children and young people's pain audit dated January 2023 to July 2023. Recent results showed 100% compliance. Questions included in the audit was if there was a care plan in place for analgesia and if there was documented evidence that the efficiency of analgesia had been assessed.

Staff were aware there was a pain management team in the trust to contact if needed. However, during the inspection we found that out of 6 medicines charts we viewed, 2 patients had been prescribed pain relief with no frequency or maximum dosage information. We a found timings were recorded accurately on the prescription charts when pain relief was administered.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.

The service participated in relevant national clinical audits to help improve outcomes. The service regularly reviewed its effectiveness through local and national audits.

Outcomes for children and young people sometimes did and sometimes did not meet national standards. We reviewed the MBRACE-UK perinatal mortality report: 2021 births which was part of the Maternal, Newborn and Infant Clinical Outcome Review Programme. Relevant to core service results showed the following: -

- The trusts stabilised and adjusted neonatal mortality rate was 1.29 per 1,000 live births. This was more than 5% higher than the average for similar trusts and health boards. The stabilised and adjusted neonatal mortality rate had consistently worsened when compared to similar trusts and health boards over the last 3 years.
- The stabilised and adjusted neonate mortality rate excluding deaths due to congenital anomalies was 1.0 per 1,000 live births. This was more than 5% higher than average for similar trusts and health boards.

The report recommended that as the neonatal mortality rates was higher than average, the trust needed to review its data to ensure it was accurate and complete and ensure that a review using the perinatal mortality review tool had been carried out for all deaths to assess care, identify and implement service improvements to prevent similar deaths. The reports were received by the trust in May 2023. This was due to be discussed at various governance meetings where actions would be discussed and agreed. The results had already been discussed at the West Midlands Neonatal Operational Delivery Network. The trust had prepared a paper for submission to governance groups which contained a summary of the key issues and continued to look into the reason for the increase.

The service took part in the national diabetes audit (NPDA) by the Royal College of Paediatrics and Child Health, 2021/22. The audit included performance on 6 key health checks; results showed the service had a better result compared to

the overall regional and national results for most key areas. Overall results of the audit showed the proportion of patients 12 and over receiving all key care process annually was 88%, this was above the national average of 70%. In relation to organisational performance compared between years: median HbA1c (mmol/mol) the trust scored 61% this was the same as the national average.

The NPDA also showed unit, region and national performance on additional health checks. Results showed the service did well compared to national average in England and Wales on blood ketone testing training, sick day rules advice, flu vaccine recommendation and eye screen health checks. Areas that scored worse than the national average were being assessed for psychological support and HbA1c measurements. Leaders monitored NPDA data with informatics providing leaders with a quarterly review on performance around care processes.

The service had participated in the EPILEPSY12 2023 audit Royal College of Paediatrics and Child Health. We reviewed the performance indicators and found that the trust scored better than the England average in 7 out of the 13 categories. Areas identified as scoring lowest in comparison to the England average included tertiary involvement, which was 14% in comparison to the England average of 53%, Electrocardiogram (ECG) was 20% against the England average of 69%, magnetic resonance imaging was 25% against the England average of 70%. The trust did particularly well in relation to other areas such to accuracy of diagnosis (100%), Sodium valporate for all females (100%) and comprehensive care planning content (90%).

Leaders told us that paediatric epilepsy outreach clinics had not taken place in the last 3 years due to lack of capacity from a tertiary centre. The centre has now had new recruits so it has been asked if these could restart. There was no specific action plan in place regarding this, however leaders told us a quality improvement project was being undertaken regarding Epilepsy 2. Actions on the risk register included agreeing a trajectory for recovery of data input and reviewing administration needs.

The service had also been involved in various other quality improvement initiatives including the West Midlands Childrens Network Peer review (April 2023), the NDQP Peer review (June 2022), quantitative behavioural testing (QB) testing to support attention deficit/hyperactivity disorder diagnosis and baby friendly initiative accreditation.

The service participated in the National Neonatal Audit Programme. Updated results from 2022 showed the trust met the national standard for mothers who delivered babies between 23 and 33 seeks gestation and were given a dose of antenatal steroids, and babies of very low birth weight or below 32 weeks gestation who receive appropriate screening for retinopathy of prematurity. They did not meet the standard for mothers who delivered babies below 30 weeks gestation receiving magnesium sulphate in the 24 hours prior to delivery, and babies below 32 weeks gestation who had a temperature taken within an hour of admission that was between 36.5°C and 37.5 °C. Actions had been identified including using quality improvement to optimise therma care of very preterm babies.

The trust had participated in a peer review of paediatric diabetes services in June 2022 in collaboration with the Royal College of Paediatrics and Child Health National Diabetes Quality Programme. Achievements were noted as the service having a dedicated and cohesive team who were working hard to improve care for their patients despite staffing challenges, who consistently delivered patient focused care. Recommendations included increasing nursing provision and that job plans for the medical provision within the service were reviewed in addition to recommending IT systems were reviewed due to issues with interfaces between different systems. In response to the peer review a business case had been developed and presented to the executive team addressing all the issues raised, however no funding was available. Leaders had also made a bid to a third-party fund for support which was unsuccessful. At the time of the inspection discussion was taking place regarding a resubmission of the business case to address the concerns. This was recorded on the departments risk register.

Services for children and young people

There was a peer review undertaken of the level 1 paediatric critical care and surgery in children by a children's network. Findings included exploring further opportunities to improve such as vascular access provision, transition and the negative appendicectomy rate for suspected appendicitis. Positive feedback from the visit included the virtual ward service and an excellent, proactive and well engaged team focussing on caring for critically unwell children in addition to having in place robust plans and systems which instil great confidence. It was also noted that it was vital from a safety perspective that safeguards were put into place to ensure that all staff were clear on the current protocol for using paediatric early warning scores and able to escalate accordingly. Leaders told us action points would be picked up at a subgroup meeting in August 2023.

We reviewed the activity data for emergency surgery slide. The slide showed that all children requiring immediate surgery were in surgery in the required timescale 100% of the time, and urgent cases almost 100% of the time.

Managers and staff used the results to improve children and young people's outcomes. There had been a quality improvement project “Improving the clinic journey for our patients”. The purpose of the project was that all patients received 4 multidisciplinary clinic appointment clinics per year in the right clinic, at the right time and seen by the right team. Patients to experience a positive clinic within a friendly environment and provide feedback on their care/clinic experience. To improve outcomes the trust had taken several steps including reviewing clinic capacity, naming clinics offered to achieve the right clinic and right time. Patient feedback was positive, and results showed an increase in clinics available. Innovative practice was also identified, such as a paediatrics diabetes pop in health clinics and free parking.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw leaders completed local audits on a regular basis to see if results had improved.

Managers shared and made sure staff understood information from the audits. Managers shared learning with staff in a variety of ways including emails, via huddles and in governance and staff meetings.

Competent staff

The service made sure staff were competent for their roles. Managers had an appraisal system in place to appraise staff’s work performance; however, at the time of the inspection appraisal rates remained low.

The clinical educators supported the learning and development needs of staff. There were both medical and nursing clinical educators in post. There were clinical and educational supervisors for all junior doctors; the supervisors were provided with protected time for this.

There were 4 different competency books on the neonatal unit and staff completed up to 3 of these. The practice development nurse was responsible for reviewing competencies and updating the relevant spreadsheet accordingly.

The staffing rota was based on competency completion, as until staff had completed the neonatal intensive care qualified in specialty course, they would care for intensive therapy unit babies under supervision of a nurse who had a QIS qualification.

If a nurse was newly qualified or an internationally recruited nurse, they had to complete the preceptorship document. If a nurse started on the neonatal unit but was not newly qualified or an international recruit, then they would be given the neonatal staff nurse competency book which the staff member kept once completed.

Leaders kept a record of who had completed the competency documents. Staff were not added to staff bank until these documents were completed. All staff completed a neonatal drugs competency, and they were not able to give oral drugs until this had been completed. Staff were given 12 months to complete these documents.

Staff told us how they had completed simulation training and role play, such as how to care for people with a learning disability.

Nurses attended the foundations in neonatal care university course which had a competency document as part of the assessment. Not all staff had completed this as some staff were employed before the course was created. All new starters since 2021 had completed this course or had a place planned. This competency document included high dependency care competencies.

Nurses were also sent on a neonatal intensive care university course, and this had a competency document as part of the assessment. All staff who had been on the unit for longer than 12 months had completed 1 of the 2 initial documents, which was the maximum timescale required by the trust.

We reviewed a blank copy of neonatal competencies workbook for band 5 nurses and a 12-month preceptorship programme band 5 competency document as staff kept these at home, so we were unable to see them. The neonatal competencies included areas such as feeding the dependant patient, collection of specimens, recording a patient's blood pressure, pulse and temperature and removal of a cannula.

We reviewed a trust theatres and day surgery unit in house training programme post anaesthetic care module and found it contained learning outcomes such as; understanding the principles of the World Health Organisation (WHO) Surgical Safety Checklist and handover to the recovery practitioner, that the clinician was given appropriate assistance in removing endotracheal tubes and that the patients' care was documented and handed over to an authorised person once their condition was deemed to be satisfactory. The document contained a list of mentors and was dated and signed off once outcomes were completed.

Consultant anaesthetists completed paediatric life support updates. The trust was a host site for managing emergencies in paediatric anaesthetists' courses. All new staff in recovery were compliant with their post anaesthesia care unit learning outcomes which had competencies relevant to the care of the paediatric patient. There was also a non-mandatory care of the child training package which staff could access and 42% of relevant staff had completed this.

The PAU was co-located on the paediatric ward C2, and the on-call teams covered this area as part of their portfolio of work. There was a consultant available 24/7 for advice to PAU. There was a plan to split the rota to have a consultant covering the 'front door' which included PAU. Recruitment had been completed and candidates were awaiting start dates. The paediatric inpatient unit and the neonatal unit had adopted a consultant of the week system.

There was 24/7 availability of general medical paediatric advice at Russells Hall, along with review, if necessary, as required for other services across the trust. The department also took specialist advice from other children's hospital specialists for paediatric patients and neonatal patients as part of the paediatric and neonatal operational delivery network.

Managers gave all new staff a full induction tailored to their role before they started work. We looked at 2 completed local ward inductions and a new starter orientation checklist. The induction included areas such as competencies,

medicines management, the ward environment, documentation, medical devices and infection prevention and control. There was also a neonatal staff induction book in place, however we were unable to review any completed copies of this as staff retained them at home. Leaders told us with immediate effect they would be retaining copies for storage on personal files and electronically.

Managers supported staff to develop through yearly, constructive appraisals of their work, however at the time of the inspection figures for nursing staff remained low. One hundred percent of medical staff within the service had received an appraisal within the last 12 months. All paediatric trainees were allocated an education supervisor who stayed with them for the period of 12 months, they also had support from a clinical supervisor on rotation.

Non-medical appraisals had an appraisal window of 1 April to 31 July. At the time of the inspection in June 2023, there was a compliance rate of 33% for children's outpatients, 5% for the neonatal unit and 70% for Ward C2. Leaders told us they were in the process of completing the outstanding appraisals by July 2023 and that all leads had a trajectory in place for completion.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The department was complaint with clinical and educational supervision for medical trainees in the paediatric department. There were trainers with educational supervision accreditation who provided supervision to paediatric trainees from the deanery.

There were 8 general practice vocational training scheme trainees in post who were provided with clinical supervision. There was no requirement for the trust to allocate education/career development supervision for non-training grades and medical training initiative (MTI) doctors. However, the trust had made a commitment to the development of these doctors and to treat them as any other deanery trainee. All MTI doctors had an allocated educational supervisor.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We reviewed the minutes from various meetings and saw written minutes were available for staff.

Managers recruited, trained and supported volunteers to support children, young people and their families in the service. There were the following volunteers in place: -

- 12 volunteers regularly supporting paediatric blood test clinics, alongside phlebotomists, 11 of whom were between 16 and 18.
- 2 volunteers assigned to the children's ward, all between 16 and 18.
- 4 young mentors supporting other young volunteers (sponsored by senior mentors). This will be increased to 10 in September 2023.

There was a hospital volunteer service annual report dated 2022/2023. The report detailed recruitment, training and development, roles of volunteers in addition to celebrating volunteers.

We spoke with nursing staff who had been developed to more senior roles within the trust. Others told us they felt opportunities to develop were limited.

Multidisciplinary working

Services for children and young people

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. We reviewed the multidisciplinary neonatal deaths meeting and saw it was attended by a variety of staff such as registrars, neonatologists, sonographers and bereavement leads.

Meetings were well attended from various staff groups. For example, the children's services group meetings included staff from critical care, outpatient and ophthalmology patients and safeguarding nurses.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. We observed staff from different disciples working together well with ward staff, such as those from the infection control and community teams.

Staff attended huddles with their colleagues from the emergency department. Specialist staff, such as occupational therapists, play therapists, teachers and physiotherapists visited wards and worked together with patients and staff for the benefit of the children, young people and their families.

Tertiary service advice for the neonatal unit was sought from the local tertiary unit at another hospital. Advice and support was available 24 hours a day, 7 days a week.

Transfer assistance and further advice for the neonatal service was sought from the neonatal transfer service; this was 24 hours a day, 7 days a week. Leaders told us how the support from the tertiary services both in hours and out of hours was very good and how they had built up close working relationships.

There was a standard operational procedure in place for the transfer to the paediatric intensive care unit (PICU). The procedure contained information on the pathway to guide for the transfer of a child to PICU, the referral process and time critical transfers. Additional guidelines were in place for the transfer and handover of seriously/critically ill children within the hospital and time critical transfers.

Most of the specialities used ready steady go documentation throughout the transition process, when this was not appropriate alternative checklists were used. There were transition checklists available for neurodisability and epilepsy. A health passport had been designed to utilise when appropriate.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. Staff referred children and young people to Child and Adolescent Mental Health Services (CAHMS) or intensive CAHMS (ICAHMS) when this was required.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Children and young people are reviewed by consultants depending on the care pathway. From Monday to Friday ward rounds took place at least once a day, and some days twice a day (especially for high dependency unit (HDU) patients on C2, and for intensive therapy unit (ITU) babies on the neonatal intensive care unit (NICU). At weekends leaders told us they were now having extra resources put in, which meant dedicated neonatal ward rounds in addition to paediatric ward rounds at weekends.

Services for children and young people

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. X-ray emergencies/inpatients were completed 24/7 as clinical need dictated. Routine requests were done at Russells Hall Hospital only and appointments were offered from 9 am to 5pm, Monday to Friday. If there was a planned outpatients' clinic outside of this this time or at the Guest outpatients or Corbett Hospital, then the department would be staffed, and x-ray would be available accordingly.

Imaging for suspected physical abuse examinations were performed Monday to Friday, from 9am to 5pm, unless there was a pressing clinical need when a particular element could be obtained outside these times, for example, a computerised tomography (CT) head for suspected head injury.

CT - Emergencies/inpatients were completed 24/7 as clinical need dictated. Routine requests were done at Russells Hall hospital only and appointments were offered 9am until 5pm, Monday to Friday.

Magnetic resonance imaging - Emergencies/inpatients were from 8am until 8pm, Monday to Friday and from 9am, to 6pm on a Saturday and Sunday and bank holidays. Sunday and bank holiday was on a case-by-case basis following consultant discussion with the on-call/supervising consultant radiologist.

Ultrasound -Due to the particular skill set required for paediatric ultrasound emergencies depended on the radiologist availability and the type of examination required, particularly out of hours. Monday to Friday from 9am to 5pm there was more availability, including a sonographer. Outside of these times provision was more variable. Routine lists with appropriate practitioners were at varying times through from Monday to Friday at Russells Hall hospital.

Fluoroscopy – There was limited provision as there was only 1 practitioner in this area.

Pathology services were available 24/7, 365 days a year and were provided via another hospital through the recent West Midlands collaboration.

Echocardiogram (ECHO) – Paediatric ECHO was available on site with the availability of 3 paediatric consultants who were trained in this. Outside of their availability emergency ECHO would be offered via other local services.

Endoscopy would only be offered via adult surgical teams in life threatening emergencies. This service would otherwise be provided in conjunction with other local services.

There was a play team including play specialists based on ward C2 who covered 7 days a week including bank holidays and was operational between 8am and 4pm. There was also a teacher who visited the hospital in the mornings.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We heard examples of staff promoting health, such as inviting service users and the general public along to access health advice. They also organised events in relation to world asthma day and feel-good Fridays that focussed on wellbeing.

Staff assessed each child and young person's health when admitted and provided support for any individual needs. Care plans were in place for any specific health related needs.

Services for children and young people

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff made sure children, young people and their families consented to treatment based on all the information available. We reviewed patient records and found that when required, staff had documented consent within them.

There was a consent policy in place. The policy detailed areas such as who could give consent and information on Gillick competency. It also detailed consent in relation to young people aged 16 to 17 years old as well as other relevant information including the Mental Capacity Act 2005 and the Children Act 1989. The policy had additional information on parental responsibility and consent for looked after children.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. For example, we spoke to a doctor about Gillick competence and found they had a good understanding on this.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff received mandatory training in mental health law, data showed compliance was 86%.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We observed staff speaking to young people and their families in a friendly and polite manner.

Children, young people and their families said staff treated them well and with kindness.

Staff followed policy to keep care and treatment confidential. We observed patients being treated with privacy and dignity at all times.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Staff were aware of the services available, such as specialist diets, chaplaincy services and interpreters.

Staff took the time to interact with people who used the service and those close to them in a kind and considerate way. We sat in on a children's outpatient appointment with a consultant and observed excellent interactions with the child

and their family. The consultant listened carefully to the families concerns, asked questions and sought clarification. They spoke to the child in a child friendly way, avoided jargon and showed them and explained their previous results. They explained everything they were doing in a way the child could understand and fully involved the child's sibling when relevant. The interaction was not rushed, the consultant built a good rapport with the family and explained everything in detail and gave lots of information in relation to their condition.

Staff showed an encouraging, sensitive and supportive attitude to people who used the services and those close to them.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Parents told us they felt confident leaving their child's care with the staff. We heard an example from a staff member of a time they had supported a parent to feel safe when they had been feeling nervous.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing. Patients told us they felt staff were kind and caring. We saw a baby octopus for a premature baby on the neonatal unit; the idea was that tentacles mimicked the umbilical cord to help calm the baby. We saw 1 baby who had this in their cot.

Childrens services had offered mindfulness sessions and activities on feel good Fridays. These sessions were offered to patients and caregivers, as well as staff. There was a budget for a child psychologist, however, the service had not been able to recruit into the post.

The play team had created a happy me clouds display when staff, patients and parents had been sharing something that made them happy as part of mental health awareness month. There was also a wellbeing wall with a positive tree and information on adolescent health.

There were worry worms and monsters available for children and young people with anxiety. The idea was that the child or young person fed the monster their worries and they ate them away for them.

We saw that from 1pm until 3pm was quiet time on the children's ward. This enabled children and their families to spend quality time together and provided them with time to rest.

We noted there was information displayed for families on staying safe, domestic violence and every mind matters.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave us an example of when they had brought a patient in for a visit prior to surgery as they had struggled with the situation previously. The play team had gone through what would happen on the day to ensure they were as prepared as possible. This had resulted in a positive experience for the patient who had gone into the theatre with minimal distress.

There was no mandatory formal training package for staff regarding breaking bad news. However, this was covered in end-of-life care training. It was also part of the final sign off for paediatricians in training. There were also multiple modules on e-learning for health focussing on this which were available to staff.

Services for children and young people

There was a child death policy and bereavement boxes located on ward C2 with all of the documentation, paperwork and resources that were required in the event of the death of a. There were 2 bereavement link workers and the service utilised charities who supported families through miscarriage, stillbirth and child loss.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Play therapists worked with children and young people before they had any surgery. For example, they showed them oxygen masks which children and young people could try on to see how they felt, they also had syringes to show them.

There were books available showing children and young people what to expect when they visited the hospital including information on cream on hands, cannulas and taking temperatures. Staff were able to use an app to help psychologically prepare and support families through healthcare interactions.

We reviewed a patient information folder and saw it contained information such as development in premature babies, breastfeeding, developmental care and information about the neonatal unit.

Staff talked with children, young people and their families in a way they could understand. Staff told us that families could bring in their own communication aids if they wanted to. Play therapists supported children and young people with communication through play. Staff spoke to children and young people without using jargon.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. There was an action plan in place following the NHS Children and Young People's Patient Experience Survey Benchmark Report 2020. The action plan had 13 actions and had led to improvements such as installing additional Wi-Fi boxes, updating menus to be more child friendly and being successful in bidding for funding to refurbish the playroom and parents' room.

Patients gave positive feedback about the service. We reviewed thank you cards given to staff from families. Comments included "thank you for taking such good care", "you all do an amazing job" as well as "thank you for your genuine kind care and support". Parents told us how they were kept updated and that staff came to them quickly when needed.

Is the service responsive?

Good ↑

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Services for children and young people

Managers planned and organised services, so they met the changing needs of the local population. The hospital worked with local systems and workstreams to look at new models of care with a local focus on children and young people with an emphasis on prevention and early intervention. Leaders held a weekly engagement call with the local integrated care board regarding any children's services updates.

The service relieved pressure on other departments. The hospital had set up a paediatric virtual step down ward. Patients were discharged from the inpatient ward earlier than they ordinarily would under normal care and were enrolled onto the virtual ward. Whilst on the virtual ward, signs and symptoms were closely monitored using a range of devices with clinical advice and support available remotely when required in response to live data received from devices and patient observations.

Facilities and premises were appropriate for the services being delivered. There was a paediatric unit which comprised of a paediatric assessment unit (PAU) that received referrals from the paediatric emergency department, urgent care centre, GPs, neonatal community team, Children's ward community outreach team and other primary care practitioners. At the time of the inspection there were 11 spaces in PAU; 4 trolleys, 1 cubicle /side room and 6 seated spaces.

There were 23 inpatient beds which accommodated acute medical patients including children and young people with mental health conditions.

There were 4 elective day care beds which were utilised Monday to Friday for elective case activity. The beds were used for surgical procedures and magnetic resonance imaging list, 3 funded high dependency unit spaces where level 1 care was delivered; there was also a children's outpatients department.

There was a level 2 neonatal unit for high dependency babies who required; short term intensive care support following apnoeic attacks, continuous positive airway pressure and parenteral nutrition (tube feeding).

The neonatal unit had 3 neonatal intensive care, 2 high dependency and 13 special care cots. There were also 3 cubicles for babies requiring isolation.

The neonatal unit had 2 flats with kitchen facilities where patients were offered the opportunity to be resident prior to discharge to care for their baby independently with advice and support from the neonatal team.

There was a classroom on ward C2, the room contained desks, teaching aids, filing cabinets, stationary, books and creative play resources.

There was a playroom which had toys for children to play with. There was a young persons' room which was ligature point free, for example with modified doors, bed fixed to the floor and light and wall adaptions.

There was a secret garden available for consultants' treating children with complex needs who were fearful of the hospital environment.

Staff could access emergency mental health support for children and young people with mental health problems and learning disabilities. In most cases the Child and Adolescent Mental Health Services team saw the child in the emergency department (7 days a week) prior to admission to the children's ward this meant less children being admitted to the children's ward inappropriately.

Services for children and young people

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. There was no formal co-ordination of appointments for children with complex needs/multiple diagnosis, however, the service worked in partnership with the learning disabilities lead nurse who supported children, young people and their families with appointments.

There were specialist clinics for paediatric; trauma and orthopaedics, cardiology and neurology where consultants from another local hospital delivered solo or joint clinics at Russells Hall Hospital to deliver care closer to home.

In relation to transition to adult services, young people were seen by clinical nurse specialists in dedicated nurse led transition clinics. Various specialities worked with adult team colleagues in different ways depending on what arrangements were in place. For example, paediatric clinical nurse specialists and the paediatric consultant for epilepsy had monthly joint clinics used to see patients of transition age and to discuss with the young person and family which transition service was appropriate.

Other multidisciplinary services for children and young people in transition to adult services included established joint diabetes clinics with paediatric and adult consultants and nurses and joint gastroenterology clinics with paediatric and adult consultants and clinical nurse specialists.

Consultant paediatricians undertook out-patient clinics at 2 schools. Consultants reviewed as many diagnoses as possible at the visit within their scope of expertise. This saved children and young people having to attend the hospital multiple times.

There was a children's ward outreach team which was made up of a small team of specialist nurses from the ward who supported children and their families at home after they were discharged from hospital. The team could offer advice and carry out tasks such as wound care. They were also able to give some speciality medicines at home.

Managers monitored and took action to minimise missed appointments. There were posters displayed in the outpatients' department in relation to a text appointment reminder service that was in place to help prevent missed appointments.

The safeguarding team received a monthly report for children who were not brought to appointments and were able to identify children who have not had a missed appointment notification form completed by the clinician when a child had a child protection plan or a child in care flag and returned to the team for distribution to community services such as health visitors or school nurses. The clinician would then be expected to complete and return the form to safeguarding for distribution.

There was a letter template staff could send out to health visitors and GPs to advise of missed hospital appointments. There was a patient access and referral to treatment policy in place.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. The paediatric unit at Russells Hall Hospital had clinical nurse specialist teams including specialist nurses in diabetes, neuro-disability, gastroenterology and epilepsy.

Services for children and young people

Staff arranged for an introduction to the neonatal unit for parents which included a tour, updates, information on infection control and parking permits.

Leaders had arranged a superhero fun run and family fun day in collaboration between the charities and paediatric clinical nurse specialist team. The team wanted to be able to invite service users and the general public along to access heath advice and support in relation to a number of services including asthma, epilepsy, diabetes, mental health support, health visitors and other community projects. The aim was to allow access to services in a fun and informal setting and create links into healthcare. Leaders told us the event had been very successful.

The team had also organised a world asthma day event. The event took place at a soft play centre and service users and families/carers were invited along. The purpose of the event was to engage children and families in health discussion in a relaxed, fun environment. This gave families the opportunity to develop links and a support system with other families.

The hospital had a chaplaincy team, who were available to patients and their families if needed, chaplains of different religions could be requested and there was a multi faith and prayer room within the hospital. There was no specific room for breaking bad news but there were quiet areas available if needed.

The trust provided staff with Makaton level 1 training; 75% of staff were level 1 Makaton trained.

For all patients with learning disabilities there was a checklist which staff completed on admission. This included areas such as use of the learning disability care plan, communication needs, assessing pain, reasonable adjustments and safeguarding. There was a learning disability pack available the pack contained a flagging information letter, flagging consent letter, learning disability checklist, care plan, health passport and flagging card.

There was a children with learning disabilities specific care plan that staff could use which included actions, such as ensuring all the team were aware that the child had a learning disability, appropriate use of the communication passport and allowing adequate time for them to complete tasks.

To support patients with learning disabilities and/ or autism there were a number of specialist initiatives to support their stay on the ward. This included worry worms to help children with anxiety, a sensory room and sensory trolley available for use by inpatients. A hi lo bed was also available. Therapy dogs were also utilised within the service.

Wards were designed to meet the needs of children, young people and their families. There was a sensory room with different lighting where children and young people could go to relax in a safe environment.

There was a sensory pod for children and young people and for people with a learning disability. This was located in the trauma and orthopaedic department.

There were parents flats available with family living areas a kitchen and shower facilities.

There was a dads pad available, and we saw an information booklet tailored to the needs of dads with information such as contact numbers of support groups and paternity leave.

Children and young people could access the internet to keep in touch with friends and family whilst in hospital. We saw there were child friendly ways to ask children and young people about their experience of the hospital Wi-Fi.

Services for children and young people

The service had access to information leaflets available in languages spoken by the children, young people, their families and local community. Staff showed us how they accessed some information in other languages, for example, staff were able to print off an information leaflet on croup which had details of other languages the leaflet could be made available in as well as being available in large print and an audio version. Other staff told us that this was an area that required some improvement.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff could access interpreters for children, young people and families if required.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. The catering team were able to support with specialist dietary needs as and when required.

Staff had access to communication aids to help children, young people and their families' become partners in their care and treatment. There was a play team in place who were able to support children with communication and understanding, such as through the provision of pictorial books of surgery. Staff welcomed children and young people bringing any specific communication tools of their own.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were not always line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Outcome analysis from the September 2022 rapid evaluation report of Dudley Group of Hospitals step-down paediatric virtual ward, concluded that for most patients, it was judged that between 1 and 3 inpatient bed days were released and an average of 3 emergency department/paediatric assessment unit visits were avoided.

There was an admitting pathway in place. Children and young people could be admitted to the PAU in 2 ways, a phone call to the unit from a GP or urgent care centre or an emergency department referral. On occasions patients seen in outpatients were sent to the PAU when there were concerns about their health. There were clear processes in place around this.

All admissions to PAU were categorised following nursing triage and observations. This placed the child/young person into a numerical triage category, so the child or young person was seen based on the acuity of their medical need, for example, red to be seen immediately, pink within 15 minutes, orange within 30 minutes and green within 4 hours.

Oversight of the waiting times was maintained by the managing director of the specialty, who then worked with the surgical teams to ensure appropriate listing of patients based on clinical priority and waiting times. They also worked with the operating theatre teams to identify any additional capacity to help restore services back to their pre COVID-19 levels.

We reviewed the most recent Facing the Future: Standards for Paediatric Services Audit dated July 2020 to September 2021. The audit looked at specific standards; results showed the trust met 9 out of the 10 standards. The standard that was not quite met was that at least 2 medical handovers every 24 hours were led by a consultant paediatrician. Results

showed the number of patients seen by a consultant paediatrician within 14 hours was 27 out of 50 patients in summer and 44 out of 50 patients in the winter. To improve compliance, further PAU resident shifts for consultants were introduced until 9pm in winter and 6pm in summer. We asked when the next audit would be taking place to determine if there has been any improvement, however we were not provided with this information.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. At the time of the inspection the waiting list for key paediatric surgical specialities for patients who required an operation showed 80 waiting for paediatric general surgery, 311 for trauma and orthopaedics, 130 for paediatric plastic surgery, 4 for ophthalmology and 125 for ear nose and throat. The number of children and young people waiting for these services over 52 weeks were 64 whilst 203 children and young people were waiting between 18 to 52 weeks.

Following the inspection, we asked the trust what they did about waits for surgery. Leaders told us the division monitored long waits and all of the children on the lists were prioritised in accordance with the measures in use across all elective surgery. All parents were provided with the contact details for the service in case they had any concerns and routine follow ups continued in the time during which the child was awaiting surgery. There were no children across the trust that were awaiting urgent surgery or who were at risk of breaching the 78 or 65 week targets for elective surgery.

Each surgical team had access to a patient tracking list which contained information on waiting times and clinical priority. This information was used by the consultant and secretarial teams to monitor waiting times and identify the order in which children and young people were listed for surgery.

The surgical teams used the national prioritisation system to categorise patients. Where there were mixed lists of adults and children; children were given priority in terms of list order. Where there were a number of children on a list, age and other clinical needs were taken into account to determine list order, for example, if a child had a learning disability or diabetes they would be prioritised.

There was access to urgent /next day clinics. Urgent appointments were provided by specialist service teams. For example, Ophthalmology held urgent referral clinics, Monday to Friday; trauma and orthopaedics held virtual fracture clinics from Tuesday to Friday. They also set up additional clinics on a weekend when needed due to capacity and were also looking to extend the service to include Monday's and ear nose and throat held emergency clinics from Monday to Thursday.

Technology systems were used to support timely access to care and treatment. For example, the service had been able to increase the update of diabetes technology and offer a choice of insulin pumps to patients. The service also had access to funding to facilitate quantitative behavioural (QB) testing. The QB test is a diagnostic screening tool which provided objective information to aid the assessment of attention deficit disorder (ADD) and attention deficit/ hyperactivity disorder (ADHD). The test used age and gender matched comparisons to assess a child's ability to concentrate, their movement and impulsivity QB test was an essential part of the ADHD pathway, and the results were used in conjunction with other ADD/ADHD assessment tools to aid clinical judgement.

Pagers were available for families in the outpatient's department where there were potential delays to clinics to help improve the patient's journey.

Children leaving the department without being seen were reported on the electronic incident recording system. We reviewed a listing report for these incidents and found it contained information such as a description of the situation, action taken at the time, severity and if an investigation was required.

National guidance was that for patient appointments cancelled by the hospital patients should be readmitted every 28 days. The support manager for elective admissions looked at potential breaches and worked with each directorate to ensure the patient was given a new date within the target and if not the reasons why for example, patient choice.

Paediatric outpatients offered a partial booking system where outpatient clinics were booked only 6 weeks in advance. However, if clinics were cancelled at short notice (for example, due to sickness) the medical secretaries reviewed the clinics and ensured patients were rebooked in a timely manner. In some case consultants set up additional clinics to reduce waiting times. If it was not possible to rebook the clinic, patients were placed back on the partial booking system. Outpatient performance was monitored and overseen by departmental managers.

Managers and staff started planning each child and young person's discharge as early as possible. Discharge letters were sent to GPs and other relevant healthcare professionals. Leaders told us how they were looking at how they could replicate the home for lunch initiative used for adults.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. We noted there was a box on the children's ward where children and young people could leave feedback on the service.

It was easy for people to use the system to make a complaint or raise concerns. There were child friendly children's feedback forms with teddy bears with different facial expressions to help children rate their experience of the service.

We saw leaflets were available for the children and young people survey which had characters with differing facial expressions and was children and young people friendly. In the outpatient waiting area we saw child friendly ways to ask about the experience of their Wi-Fi.

The service clearly displayed information about how to raise a concern in patient areas. We saw letters on a young person’s bedside saying how to make a complaint. Compliments and complaints information was displayed on notice boards.

Staff understood the policy on complaints and knew how to handle them. The complaints and concerns policy included sections on complaints by or on behalf of children and covered timescales, recording of complaints, local resolution meetings and learning from complaints. Staff were able to tell us what they would do if a patient made a complaint to them, such as local resolution and escalation to more senior staff.

Managers investigated complaints and identified any learning. We reviewed 3 complaint responses and saw they had been investigated, apologies provided and that those raising the complaint were provided with the details of the Parliamentary Health Service Ombudsman if they were not happy with the outcome of the complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback was given in a variety of ways such as in staff meetings, in emails and huddles. We reviewed a copy of team meeting minutes and saw complaints were on the agenda. For example, in March 2023 we saw a complaint around the timeliness of a clinic appointment was discussed. The concern had also been shared at a clinical audit and governance meeting.

Services for children and young people

There were improvement huddles and boards with information such as how many complaints had been received and you said we did examples.

Complaints were reported on in children's services governance reports. For example, the report showed that in March 2023 there were 5 complaints which included admissions, discharges and transfers, appointments delays and cancelations, values and behaviours and patient care including nutrition and hydration.

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.

Children and young people's services sat under the surgery, women and children's division at the trust. There was a clear leadership structure in place which included a directorate manager, clinical director, head of children's services and a matron.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Examples of challenges discussed during the inspection included the medical and nursing workforce. Actions taken to address this included completing business cases to allow split rotas, reviewing apprenticeships and asking for additional funding.

Staff felt that leaders were visible and approachable. During the 2 days of inspection, we observed leaders to be highly visible.

Consultant job plans were flexed in summer and winter due to increase in demand through the winter period (October to March). In the summer months the consultant remained on site on weekdays until 6pm and in the winter the on-call consultant remained on site until 9pm. At the weekend the consultants remained on site from 9am to 4pm in the winter and from 9am to 2pm in the summer, however, during times of high demand the consultants would remain on site to support.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Services for children and young people

The hospital had a vision of excellent health care and improved health for all. The goals were to deliver the right care every time, to be a brilliant place to work and thrive, to drive sustainability, financial and environmental, to build innovative partnerships in Dudley and beyond and to improve health and wellbeing. Trust values formed part of the recruitment process and were included in annual appraisals.

We saw a vision board staff had compiled on where they wanted to see the service in 6 months. This had enabled the lead nurse and matron to focus on specific areas that were important to the staff and to regularly discuss progress. These staff visions were what the team based its yearly objectives on. Areas highlighted for focus included; staffing, resilience and morale, positive culture and key performance indicators.

The trust had identified how they would measure success in relation to this such as reducing vacancy rates and outstanding CQC ratings. Programmes to support this included the Black Country system service transformation, local leadership to address health inequalities and research and development, education and innovation.

There was a strategic plan in place dated 2021 to 2024. Goals cited in the strategy included partnering with, other acute trusts in the Black Country, health and social care organisations, the voluntary sector and local academic institutes.

The Children's Services Annual Report 2022/23 reported that the children's services were currently developing a strategy to inform the aspirations for the service and that this would be aligned with national, local and trust aims. The plan was for the strategy to encompass several transformation programmes looking at opportunities for a blended workforce, workforce wellbeing, same day emergency care pathways as well as community pathways.

Culture

Staff opinion varied around feeling respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

Staff opinion varied around feelings of being supported and valued. Some staff spoke of low morale and being pulled in every direction. Other staff told us they loved their job, worked with an amazing team but that they did not always feel recognised or that their past experiences were valued.

Staff felt proud to work for the organisation and the culture centred on the needs and experience of people who used the services. Staff were provided with equality and diversity training, including autism awareness, and overall compliance rates were high at 96%.

The service provided staff with opportunities to develop for example, by sending them on courses relevant to their specialty or being promoted into more senior roles.

We met with staff who had been developed within the service and others who felt career development was limited.

We observed cooperative and supportive relationships between staff. They worked collaboratively and constructively, sharing responsibility. This was especially evident in daily huddles both on wards and with the paediatric emergency department.

The service promoted equality and diversity staff networks Leaders displayed posters in staff areas on available networks such as disability and lesbian, gay, bisexual, transgender and queer (LGBTQ+).

We saw a poster on Schwartz rounds in a staff area, these were an opportunity for staff to get together to discuss the emotional and social aspects of working in healthcare.

We saw staff were celebrated and there were initiatives to improve staff wellbeing, such as a positive wall and star of the month. We noted that leaders had celebrated the star of the month in a team meeting when a staff member was commended for always staying calm, positive and for being a great team player.

During the inspection we came across 1 example of poor staff conduct in relation to the care of a young person on the ward that had not been escalated appropriately. We raised this with the trust who took immediate actions to address our concerns. This included identifying the staff involved, emails to staff and daily huddles around the behaviour framework and the Nursing and Midwifery Council code of conduct. These documents were also displayed in communal areas for staff information.

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.

All levels of governance and management functioned effectively and interacted with each other appropriately. There was a divisional structure for governance for paediatrics and neonates. This included a board of directors, quality and safety committee and a divisional management team.

There were governance assurance meetings in addition to 6 weekly children's services audit and governance meetings, bimonthly neonatal quality practice development team meetings, bimonthly quality practice development team meetings and weekly meetings with maternity and maternity safety champions meetings.

Processes were in place to report on performance. For example, paediatrics sat as part of the Surgery, Women and Children Division and reported upwards to the senior management team. The directorate triumvirate met up with the director of operations, chief of surgery and divisional chief nurse monthly as part of the specialty performance and quality meetings.

Operational board meetings took place once a month and staff were invited to speak to the board including clinical governance leads who gave updates to the board.

We reviewed the children's services annual report dated 2022/23 and found it contained information on activity and performance, including average length of stay, imaging performance, surgery in children and information on children and adolescent referrals for mental health needs.

We reviewed the board meeting minutes and found that the board were sighted on an incident that had occurred within the service and that this had been discussed.

Childrens services governance reports were produced monthly and covered areas such as incidents, complaints, risks and quality audits. They also looked at areas, such as mandatory training, documentation and mortality and morbidity.

Services for children and young people

We reviewed the paediatric and neonatal monthly audit clinical governance meeting minutes from April 2023 and saw areas for discussion included celebrating the success of the virtual ward which had been short listed for multiple awards. Other topics of discussion included audits, safety alerts, risk register reports, incidents and the associated top 3 themes, policies and guidelines including policies for ratification as well as mortality reports and external visits.

Multidisciplinary reviews of neonatal deaths meetings were held monthly and contained case presentations, comprehensive discussions and actions identified during reviews.

Ward meetings detailed audit results, quality, appraisals and new processes for example we saw that in April 2023 the process for transporting blood gas was discussed.

There was a paediatric emergency pathways daily huddle in place with terms of reference. Membership included the consultant of the week for paediatrics and emergency medicine, the nurse in charge of paediatrics and the paediatrics emergency department. The huddle took place twice daily. The purpose of the huddle was to facilitate patient experience, flow, safety and shared learning.

Staff at all levels were clear about their roles and understood what they were accountable for and whom they were accountable to. Leaders ensured both local and national audits were completed and reported on.

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.

There was a departmental risk register in place that contained risk, mitigators, risk ratings and action required. At the time of the inspection there were 14 risks. Risks were colour coded to show the level of risk with red being the highest. There were 2 risks rated as being in the highest risk category, these were lack of paediatric follow up capacity resulting in delayed follow up appointments for children and the neonatal unit footprint being non-complaint to national standards. The risk register was discussed in governance meetings as well as in consultant meetings.

There was a programme of clinical and internal audit to monitor quality and operational processes and systems to identify where action should be taken.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions. There was an alignment between the recorded list and what staff said was on their worry list.

Leaders were aware of any risks or issues relating to mental health in relation to their ward. We noted that the risk register contained a risk relating to children and young peoples' services in relation to metal health and extreme behaviours and a risk of emotional and physical harm to patients, staff and other service users. Mitigations included mental health law training, screening harmful behaviours from others and the provision of a specialist child and adolescent mental health services cubicle.

Leaders were aware of the challenges in winter and talked of the impact of virtual wards on patient flow within the system. There were also plans for other initiatives such as looking at specific pathways for treating patients at home and to reduce cubicle capacity.

The service had weekly meetings with the local integrated care board and other local systems to discuss capacity and pressures. Leaders told us how this had built up a good network.

Services for children and young people

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.

There were computers available for staff to ensure they could access any electronic patient records; these were password protected to ensure confidentiality at all times**.**

The trust had implemented a deteriorating patient pathway (DPP) which was launched trust wide on the electronic patient record system in November 2022. The DPP was a live system for all leads, matrons and consultants to have oversight of their areas giving data that the trust had not previously been able to analyse or access.

At the time of the inspection, the trust were not yet fully electronic in relation to all patient information. This meant that staff were still having to use both paper and electronic notes.

Leaders told us how the current electronic patient record system had not been designed in its current format to be used for children. Most of the paperwork had now been converted into a format that was compatible.

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 surveys were completed and the most recent results for 2022 showed the service did well in relation to the organisation acting on concerns raised by patients and service users. However, it did not do so well in relation to having adequate materials, supplies and equipment, never/rarely being burnt out because of work, never/rarely being exhausted by the thought of another shift, disability and the organisation having made reasonable adjustments to enable staff to carry out their work.

As a result of the staff survey initial planning had taken place and areas of focus had been identified. For example, completion of appraisals, developing a learning journey for the neonatal team and dedicated psychological support for neonatal staff.

The service sought out feedback from children, young people and their families. We heard how the department had worked with a local group of young people to gain advice on how the service could be improved such as how waiting areas could be more child friendly and ideas for Christmas parties.

The service had taken part in the 15-step challenge. The challenge was designed by a mother and developed as a way of feeding back. The hospital also had regular meetings with the local integrated care boards to help improve services for patients.

Leaders reported performance data to key stakeholders. We reviewed the medical paediatrics performance update spreadsheet and found it included information in monthly referral figures, did not attend rates, complaints, triage information and incidents.

Services for children and young people

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.

Leaders had put together a business case to increase medical staffing in the department. This had been successful and resulted in an extra 5 consultants which allowed the service to split paediatric and neonatal rotas.

In medical paediatrics there were 2 hot clinics per week, usually on a Tuesday or Wednesday morning. The clinics were for children and young people who needed a senior paediatric opinion but were unlikely to need admission.

The service had introduced a patient initiated follow up, at the time of the inspection there was 100 medical paediatric patients on the pathway. The pathway gave greater onus on parents/carers in respect of their child's needs.

The service had also been involved in various quality and service improvement initiatives and peer reviews to improve the service, including the quantitative behaviour (QB) testing to support attention-deficit disorder (ADHD) diagnosis and baby friendly accreditation.

There were plans in place to relocate the paediatric assessment unit to the paediatric emergency department as both were quite far apart from each other at the hospital.

The service was working with a company to source new monitors that would automatically upload observations to an electronic system and perform wireless monitoring to ensure children could move around whilst being monitored.

The service had introduced a single point of access for children under 5 with behavioural concerns. This was a multidisciplinary approach with early years, health visitors, paediatricians, children's autism service and speech and language therapy. The aim was to ensure children were receiving the right care at the right time and to reduce delays.

Fun days were held monthly. We saw as part of these staff had dressed up as Alice in Wonderland characters to raise money for the children's ward. Previous events to raise money for the ward had included staff dressing up as Star Wars, superheroes and other characters. The ward had also held a sports and games day for children, staff team events and a karate demonstration for students from local karaoke federation. A fundraising campaign had also been held to raise cash for beds so children could stay with their children.

Outstanding practice

We found the following outstanding practice:

The hospital had set up a paediatric virtual step down ward in March 2022. Information reviewed following the inspection showed that between March 2022 and August 2023, 593 patients were supported, 2374 bed day capacity was created, 1664 emergency department/paediatric assessment unit visits were avoided, and 1849 clinical hours were created. The trust had supported 630 children with 12 virtual ward beds. Patients were discharged from the inpatient ward earlier than they ordinarily would under standard care and were enrolled onto the virtual ward. Whilst on the ward signs and symptoms were closely monitored using a range of devices with clinical advice and support available remotely when required in response to live data received from devices and patient observations. Milestones to date were winner Dudley Group NHS Foundation Trust committed to excellence awards, and finalist

for Royal College of Nursing Awards, Nursing Times Awards for children's services and technology and data in nursing (October 2023). Leaders told us how learning in relation to this had been shared far and wide and the hospital had a meeting set up with a hospital in America to assist in them setting up their first paediatric virtual ward.

Areas for improvement

MUSTS

The trust must ensure that

- The trust must ensure the service improves compliance in relation to national guidelines on staffing levels. (Regulation 18).
- The trust must ensure that they maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. (Regulation 17 (1) (C)).

SHOULDS

The trust should ensure that

- The trust should ensure that medicines charts are completed correctly. (Regulation (12) (2) (g)).
- The trust should continue to review and identify if their training meets the statutory learning disability and autism training requirements. (Regulation 12).
- The trust should ensure all staff receive a regular appraisal (Regulation 17).
- The trust should continue to act on the recommendations of the MBRACE-UK perinatal mortality report. (Regulation 12).
- The trust should ensure they improve their performance in relation to their deteriorating patient pathway measures. (Regulation (12) (1)).
- The trust should ensure they continue to improve compliance in relation to national guidelines on Quality in Service trained staff in line with its trajectory (Regulation 18).
- The trust should ensure that all areas are organised, tidy and clutter free and that oxygen masks are kept organised for ease of access. (Regulation 12 (1))
- The trust should ensure they continue to improve compliance in relation to mandatory training around resuscitation. (Regulation 18).