East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Inspection report

Kennington Road
Willesborough
Ashford
TN24 0LZ
Tel: 01227886308
www.ekhuft.nhs.uk

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Ratings

Overall rating for this service

Requires Improvement

Our findings

Overall summary of services at William Harvey Hospital

Requires Improvement 

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

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

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

During the inspection, we visited Padua ward, the neonatal intensive care unit, theatres, recovery, radiology, fracture clinic, the rotary suite, and the children's outpatient department at the William Harvey Hospital. We spoke with five parents, two children and 29 staff including; nurses, doctors, managers, allied health professionals and support staff. During our inspection, we looked at six sets of patient records.

How we carried out the inspection

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

Services for children and young people

Requires Improvement  

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

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

However:

- There were two key questions rated requires improvement at the last inspection. We did not fully inspect these key questions which meant we could not rerate these.
- Not all staff had completed paediatric hospital life support training.
- One small waiting area in radiology was used by both children and adults. The area was cleared of toys, books and games for COVID19 safe working and infection prevention and control precautions.
- Not all incidents were investigated in a timely way.
- Not all staff were following the trust's policy for pre-operative fasting.
- Not all staff were aware of the service's draft vision.

Is the service safe?

Good 

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

Services for children and young people

Mandatory training

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

Nursing and medical staff received and kept up-to-date with their mandatory training. Staff had to complete nine statutory training modules and five mandatory training modules.

The compliance for the statutory modules was; 91% for fire safety, 96% for health and safety, 92% for information governance, 95% for equality and diversity, 100% for infection prevention and control level one, 92% for infection prevention and control level two, 93% for moving and handling, 96% for safeguarding children and young people level 2, and 91% for safeguarding and young people level 3. All the statutory modules met the trust target of 85%.

The compliance for mandatory training modules was; 100% for safeguarding adults level 1, 89% for safeguarding adults level 2, 85% for hospital life support, 66% for paediatric hospital life support, and 68% for hand hygiene. However, audit records showed staff were following hand hygiene guidance and good practice. All but two mandatory modules met the trust target of 85%.

Not all staff had completed the resuscitation training. Managers told us this was due to the pandemic which had resulted in a reduction in face to face training. Staff told us they felt well supported while this training had been delayed for some staff. Staff received additional resuscitation training during this time which included; simulation training, online learning and informal training provided on the wards. Managers ensured there was always a member of staff trained to deliver paediatric life support. They held a daily meeting to check staffing levels including confirming there was at least one member of nursing staff with the correct training for the day and night shift.

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

The mandatory training was comprehensive and met the needs of children, young people and staff. Leaders of the service had conducted a learning needs assessment to identified what staff needed to know to provide safe care and treatment to children and young people.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said their managers would remind them when they needed to complete mandatory training.

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. All staff with patient facing roles were required to complete safeguarding and young people level 3 training which was in line with the standards set out in the intercollegiate document for healthcare staff providing care to children.

Services for children and young people

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. The service had a system to flag children with a child protection concern on their record. Staff told us this system helped them identify children that had been identified as at risk of abuse. Staff on the neonatal intensive care unit completed an abuse risk assessment for every admission that was then reviewed by the safeguarding team to ensure every baby was safe from abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff reported safeguarding concerns using the trust online tool and knew they could seek advice from senior staff or the trust's safeguarding team.

Staff followed safe procedures for children visiting the service as outpatients. Staff knew how to identify concerns and had a system to record concerns about possible abuse. This system allowed them to review all other entries made by other staff about possible abuse in one place. Staff told us this allowed them to see themes in the concerns which could show a pattern of low-level abuse not evident on an individual interaction with the child.

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 visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and showed cleaning was being done regularly. We saw staff cleaning the areas we visited. Staff cleaned equipment after patient use and used green labels which showed when items had been last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff we saw during the inspection were 'bare below the elbows' and dressed in line with trust policy. Staff had access to aprons, masks and gloves in a variety of sizes. Staff used this equipment in line with trust policy. The trust policy was up to date and followed the national guidance on use of PPE in hospitals. Staff told us they were happy to challenge noncompliance.

Audits including hand hygiene and use of personal protective equipment were undertaken to monitor compliance with infection control standards. The compliance for these audits in July 2021 was 98.1% for Padua Ward and 99.4% for the neonatal intensive care unit. Staff used this information to drive improvement where required. Environmental audits were used to monitor the effectiveness of cleaning.

All staff cleaned their hands before, during and after patient care in line with the World Health Organisation guidance on the "five moments for hand hygiene". We saw posters reminding staff of these five moments. Reception staff reminded staff and visitors to use hand gel on entering the ward.

The service had enough sinks and alcohol hand rub dispensers to support compliance with hand hygiene. We saw no queues for sinks and saw alcohol hand rub was available at the entrance to the ward and all departments used by children and young people. All sinks had soap, disposable hand towels and posters displaying the correct hand washing technique.

Services for children and young people

Infection control audit performance was reported to the infection control committee which met monthly. These audits were completed by ward staff and results were shared with them. The specialist infection control nursing team also completed audits to compare with the results of local audit data. The last specialist infection control nursing audit in July 2021 showed 100% compliance.

The service followed national and local policies to reduce the spread of infections. They had adapted their ward to have three separate areas. They streamed patient with suspected COVID-19 into one area and those patients with no symptoms into another area. The third group of patients were those with planned admissions that had been isolating in preparation for their admission. We saw patients were also placed in single rooms when they were vulnerable to infection to reduce their contact with staff and other patients.

Staff managed sharp clinical waste in a way that reduced the risk of spreading infections. Sharps bins were assembled correctly, and these were not overfilled. Staff used temporary closure lids to reduce the risk of accidental sharps injuries.

The service had maximum occupancy signs to alert staff, visitors and patients to the maximum number of people that could safely socially distance in each room. We saw 15 rooms had these signs displayed however we also saw four rooms without these signs. We alerted managers to the absence of these signs and they immediately replaced the signs. All the rooms without signs were empty when we visited.

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 service had suitable facilities to meet the needs of children and young people's families. The service had separate areas on the ward for younger and older children. They had indoor and outdoor play areas although due to the COVID-19 pandemic there were restrictions on the use of these areas to only allow one child at a time. The service had a cleaning program to ensure all toys and play areas were cleaned between each use. The service had dedicated specialist staff to support children with play.

The waiting areas in the children's outpatients and fracture clinic were separate to adult waiting areas. In the radiology department, children waited in designated areas however, these were not separated from the adult areas. On our visited there were adults in the areas staff told us were used for children to wait. Staff told us they prioritised seeing children to reduce the time children waited in these areas. This had improved since our last inspection, when there was no consideration of separation between adults and children in waiting areas.

The service had enough suitable equipment to help them to safely care for children and young people. Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was available on the children's ward, outpatients, and theatres. Staff completed daily checks and used tamper proof numbered tags to show if the contents had been accessed. Staff completed full internal checks of the resuscitation trolleys weekly. We checked three trolleys and found that checks had been completed in line with trust policy.

Children, young people and their families could reach call bells and staff responded quickly when called. We heard call bells sounding and saw staff swiftly responding to the calls.

Staff disposed of clinical waste safely. Staff correctly segregated waste into clinical and non-clinical waste. The service had clinical waste bins with clear indication about what should be disposed of in them. They also had domestic waste bins for non-clinical waste which had signs on to remind people what could and could not be put into these bins.

Services for children and young people

The service had and maintained fire safety equipment to reduce the risk to patients from fire. The service had carried out yearly checks on fire extinguishers and these were secured to the wall where staff could access them quickly. All doors were closed and doors with "Fire door keep locked" signs were kept locked.

The children's and neonatal intensive care unit were secure. The children's ward required staff to allow patients and visitors in and out of the ward. The neonatal intensive care unit had secure access to restrict entry to the unit. However, visitors were not restricted from leaving the unit. Unrestricted exit from neonatal units is a risk as people may take babies out of the unit without permission and without the staff knowing. We made managers aware of our concerns and they immediately addressed the concern to restrict exit as well as entry to the unit.

The service had dedicated fridges to keep milk for babies on the ward and the neonatal intensive care unit. We saw these were not secure. If the fridges are not secured, then staff cannot be certain that people have not tampered with the milk. We raised these concerns on the day of inspection and managers immediately resolved this issue. On revisiting the areas in the afternoon all milk fridges had locks fitted and were locked.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The service used the paediatric early warning scores (PEWS) which is a national tool used to identify children at risk of deterioration. The service audited their performance in carrying out observations in accordance with their policy for monitoring patients. This audit was conducted monthly which included two parts with the first looking at all data reported by their digital observation tracking tool and the second looking at a spot check of practice on the ward. The audit showed compliance with completion of observations on time was 92% for May 2021, 95% for June 2021, and 95% for July 2021. Trends in noncompliance were identified and actions planned to improve compliance. An updated action plan was attached to this audit each month to monitor progress on these improvements.

Staff knew about and dealt with any specific risk issues. The service had a monthly audit of their compliance with the trust's sepsis policy. This audit included compliance with the use of the trust's sepsis screening tool which showed compliance on the children's ward of 90% for April 2021, 95% for May 2021, and 85% for June 2021. The service had taken action to address the 10% drop in compliance in June when they identified this drop was caused by lack of understanding of student nurses and healthcare assistants. They had reminded all registered nurses to provide appropriate supervision to students and healthcare assistants. They also looked at compliance of staff administering the first dose of antibiotic to children with sepsis within one hour which showed compliance on the children's ward of 100% for April, May and June 2021. These audits identified themes in areas of noncompliance and made recommendations for improvement. An updated action plan was attached to this audit each month to monitor progress on these improvements.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. All patient records we looked at were completed on admission and updated during the patient's stay on the ward. These included risk assessments for children experiencing mental health crisis.

Services for children and young people

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). When children or young people were admitted to the ward experiencing a mental health crisis the service had an arrangement with a nursing agency to supply them with experienced staff to care for them. These staff were often registered mental health nurses.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. Staff in the children's ward completed risk assessments for children at risk of self-harm or suicide. Specialist psychosocial assessments were conducted by specialist doctors from the children's and adolescence's mental health service.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Staff used a tool to handover care referred to as "STOPP" which included background information about the child, observations, the level of care needed and a checklist to remind staff what needed to be done for a safe transfer.

Shift changes and handovers included all necessary key information to keep children and young people safe. Staff handed over key information and used handover sheets to remind themselves of this information. During handover, staff read the message of the week which would act as a reminder or an improvement message. The message of the week for the first week of August 2021 was reminding staff about needing to complete hourly observations for patients with a high pain score.

The service had improved the safety of restraint of children and supported staff to reduce the need to use restraint. Staff on Padua ward were not trained in restraint, but were trained in de-escalation techniques. Staff called hospital security to assist with restraint when other less restrictive options were not effective. Security staff told us they undertook a four-day course with one day dedicated to carrying out physical interventions. This training was updated every three years. Nursing staff told us during physical intervention they would monitor how security were handling the situation and gave instructions in order to diffuse the situation.

The trust had a service level agreement with a provider for security staff in which it states all security staff are required to be trained in safe restraint and de-escalation techniques. Security staff are only to restrain patients under direct supervision of clinical staff, and this was recently reinforce following a meeting between the children's leadership team and the security providers leadership team.

Leaders raised concerns about the lack of available mental health beds for children. Leaders raised concerns to the local commissioning group about specific children waiting for suitable mental health treatment beds. Leaders also raised concerns to external stakeholders about the under prevision of local and national services for children and young people with mental health conditions.

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

Nurse staffing

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

Services for children and young people

The service had enough nursing and support staff to keep children and young people safe. We saw there were enough staff on the wards and units we visited. Staff reported that staffing levels had been good during the past 12 months apart from the last three weeks which had been more difficult due to leave and sickness. Managers had eight additional whole-time equivalent nursing posts recently approved. The service had some senior nursing staff working supernumerary to support across the service.

The department had a paediatric senior nurse on-call service. The service was provided during the hours of 5pm to 8am Monday to Friday and 24 hours of the day on the weekends and bank holidays. The on-call senior paediatric nurse was available to assist staff with escalating staffing concerns, bed management and provided support and clinical expertise in relation to clinical paediatric care outside of normal working hours.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. There was always at least two registered children's nurses working in the children's ward and the neonatal intensive care unit at any one time. We looked at ten staffing rotas and saw the service always met the standard to have over 70% of their staff as registered nurses.

The ward manager could adjust staffing levels daily according to the needs of children and young people. Staff worked to support each other including managers, to redeploy staff from the trust's other hospitals to support staffing in the children and young peoples service.

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

The service had reducing vacancy rates. The service had 18.4% vacant nursing posts however this included eight whole time equivalent nursing posts that had recently been created through a business case to expand their workforce. The service had recruited three full time nurses toward these eight new posts. Managers told us they had several newly qualified nurses starting with the service at the end of the summer.

The service had low sickness rates. Nursing staff for this service had an average sickness rate of 2.7% over the past 12 months.

The service had low rates of bank and agency nurses. Staff told us they did not often need agency or bank staff. The service expenditure on agency staffing was low.

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

Managers made sure all bank and agency staff had a full induction and understood the service. All agency staff had a local induction to the ward to ensure they were familiar with the environment. The neonatal intensive care unit ensured

agency staff were kept up to date with changes to the unit by requiring agency staff to repeat their induction to the unit every three shifts they completed. The agency staff member and the nurse in charge of the neonatal intensive care unit on the day they work were required to write feedback on their work during that shift. The service used this feedback to ensure the best staff were used to support safe staffing in the future and for the agency staff's development.

Medical staffing

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

The service had enough medical staff to keep children and young people safe. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The medical staffing for the children's ward was one consultant, two specialist doctors, four middle grade doctors and one foundation doctor for the morning with this reducing to two speciality doctors and one foundation doctor in the afternoons. The neonatal intensive care unit had medical staff including two consultants during the day and on call cover during the nights and weekends.

The medical staff matched the planned number. Medical staffing numbers were monitored daily which showed staffing numbers matched the planned number.

The service had low vacancy rates for medical staff. The service's vacancy rate was 15.4% for medical staff however this included eight new consultant posts created by a business case to expand their medical staffing which had not been recruited to yet. Without these posts the service had a vacancy rate of 3.1%.

Sickness rates for medical staff were low. Medical staff for the service had an average sickness rate of 2.4% for the past 12 months.

Managers could access locums when they needed additional medical staff. The service used medical locums to cover some of the new medical posts the service had created while substantive staff were recruited. They also had registrars employed as long-term locums to cover the expected surge in children with respiratory conditions this winter. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. The service had a rota of consultants to cover the on-call times, which included a consultant that would be in the hospital at weekends and on call at night.

Records

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

Patient notes were comprehensive and all staff could access them easily. Medical, nursing and multidisciplinary records in the neonatal intensive care unit were stored on an electronic system allowing swift and remote access to these records. Patient records on the children's ward were partly stored on electronic systems and partly paper. All records in both areas were complete and recorded contemporaneously. The service used paper medicine charts which they had planned to change to electronic medicine charts in the future. We saw this was part of the action plan in a medicine error incident investigation to improve medicines safety by removing handwriting interpretation errors.

Services for children and young people

When children and young people transferred to a new team, there were no delays in staff accessing their records. Patient observations were recorded on an electronic system that allowed staff to immediately access these. Staff could access these records remotely to look at patients' observations which allowed consultants on call to see trends in patient observations while speaking with staff in the hospital. When transferring neonatal babies, the transfer service and the receiving hospital had access to the medical records and observation records to monitor the babies' condition.

Records were stored securely. The electronic record systems were secured with unique usernames and passwords for each member of staff. Staff logged out of the computer systems when not in use to prevent unauthorised access. All paper records were stored in locked notes trollies.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. All medicine records were complete and up to date with clear recording of reasons if medicines were not given. Controlled drugs were stored securely, checked daily and the stock levels we checked were accurate.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. Parents told us they had been provided with advice on medicines and the service had patient information leaflets including information on medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Access to clinical rooms was restricted to staff with locked doors. All medicines were stored in locked cupboards and locked fridges located within these clinical rooms. The fridge temperatures and ambient room temperatures were monitored daily and actions recorded when temperatures were outside of the recommended ranges.

Staff followed current national practice to check children and young people had the correct medicines. Staff checked patient's identity and allergies before giving patient medicine. The service had recently undertaken an awareness month around the importance of medicine allergies.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Staff told us they received information from monthly newsletters, the weekly message, group messaging applications on their phones and via emails.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, the service did not investigate incidents in a timely manner. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff knew how to access the trust incident reporting tool on the intranet and told us if they were unsure how to report an incident they would ask for support from their manager.

Staff raised concerns and reported incidents and near misses in line with trust policy. One of the incidents we reviewed was a near miss where staff had identified a legibility concern with the dose of a medicine prescription before it was due to be administered. They were able to clarify this dose with the prescriber and learning was shared about the importance of legibility of handwriting on medicine charts.

Services for children and young people

The service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2020 to June 2021, the trust reported no never events for children's services.

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) which met the reporting criteria set by NHS England from July 2020 to June 2021. Three of these were related to a healthcare associated infection or infection control incident. One was related to a delay in treatment and one was awaiting review to determine the type of incident.

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

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they would be informed of the progress of investigations of incidents they reported. Staff told us they received feedback about incidents reported by other staff through staff posters. These posters were displayed in the staff areas of the service with a summary of the incident and the key learning points.

Staff met to discuss the feedback and look at improvements to children and young people's care. Incident learning was discussed at the service's monthly governance meetings. Feedback about incidents was shared with staff via notice boards which displayed single sheet summaries including a summary of; the incident, the route cause, good practice, areas for improvement and learning points. One had been produced following a recent serious incident which involved medicine. This shared that there had been no permanent harm to them and had also identified areas for improvement which included that staff prescribing or administering medication should wear a red arm band identifying that they should not be disturbed.

There was evidence that changes had been made as a result of feedback. We saw staff wearing a red arm band identifying them to not be disturbed.

Managers investigated incidents thoroughly. We looked at five incidents which showed a thorough investigation had been conducted and learning was identified. These had all been graded for their severity according to the trusts policy. However, the service was not meeting its target to investigate incidents within six weeks.

Managers debriefed and supported staff after any serious incident. Staff reported debriefing after serious incidents had been introduced recently and they had found them helpful.

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

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

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

Services for children and young people

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

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

Is the service effective?

Inspected but not rated

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

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

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

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

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

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

Is the service responsive?

Inspected but not rated

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

Services for children and young people

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

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

The service had added murals to the ward area and to the cycling of the route to theatres to provide children with a more comforting environment. The ward areas were decorated in a gender natural sea creatures theme.

We told the trust they must review the care of children aged 16 years old to 18 years old and ensure that their needs are fully considered.

The service had reviewed the care provided to children aged 16 years old to 18 years old and had worked to meet their needs. We spoke with patients in this age group that said they felt well supported and that the service had met their needs. Managers told us they have setup an electronic system that alerts the children's management team when a patient in this age group is admitted to a ward outside of the children's area. They also supported the patient and staff to make an informed decision about where the patient's needs would be best met. Managers told us if the child was admitted to a ward other than the children's ward they would contact the nursing staff to ensure they were familiar with the trust policies that were different for the management of a child such as allowing their parent to stay with them. This had improved since our last inspection.

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

Staff knew how to follow the trust's pathway for providing care when a child died. All staff we spoke to were aware of how to access the pathway which was contained within a dedicated box. They also knew how to get support from the palliative care team. Staff in the neonatal intensive care unit told us part of their fortnightly simulation training had been to provide care for a child that had passed away.

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.

Services for children and young people

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

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

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

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

Vision and Strategy

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

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

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

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt respected, supported and valued. All staff told us they felt leaders and other staff respected them. Staff told us bullying was not a problem in their care group. The 2020 NHS staff survey for the children's health care group showed a score of 7.8 for safe environment in relation to bullying and harassment which was better than the trust average of 7.3. In the survey, 10 is a perfect score and 0 is the worst with 8.1 being the average across the country.

Staff were focused on the needs of patients receiving care. They told us they worked together to support one another to meet the needs of their patients.

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

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff told us they raised concerns, and these were viewed as opportunities to improve the service. Relatives told us they were able to raise concerns, and these were addressed swiftly.

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.

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

The trust monitored their performance against other trusts using national audits. They submitted data to the national paediatric diabetes audit which had three measures and for the 2019/2020 audit these showed the trust was worse than expected for one measure, within expected range for one and no significant change for the remaining one measure. They also submitted data to the national neonatal audit programme however this had not been run in the past 12 months due the pandemic. The last audit showed they were within the expected range for three measures and better than expected for the remaining one measure.

The service had a weekly message to update all staff on key changes and important reminders which were read out at every handover that week.

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

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

Management of risk, issues and performance

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

Leaders and teams used systems to manage performance effectively. They shared performance information with staff via notice boards in the staff areas and via newsletters. These included information about the number of incidents reported and learning that had been taken from these.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service held monthly risk meetings to review risks on their risk register and to assess new risks. The service had a risk register which recorded relevant risks to the service. Each risk entry had been reviewed in the last month and had been updated recently. These all had an owner listed with risk controls, actions, and progress updates. The risks included insufficient placements for children with mental health conditions and a higher demand for paediatric gastroenterology service than their capacity. The service had put in risk controls to reduce the effect to patients which included the consultant for this service doing extra clinics and surgery lists, referring patients with urgent needs out of the service to an alternate treatment centre, and optimising other aspects of the patient's experience.

The service had plans to cope with unexpected events. The service had planned for major incidents including; a general major incident, a paediatric specific major incident, and a respiratory syncytial virus surge. These plans contained detailed consideration of what each part of the service would do in the event of one of these incidents occurring. This included working with other local and regional services to provide mutual aid as required.

Staff were not constrained by financial pressures from delivering safe care and quality improvements. Staff knew they needed to offer value for money especially in quality improvement but did not feel additional cost was ever a barrier to pursuing improvements to safety.

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

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

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

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

Services for children and young people

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.

The service worked well with patient representative groups, children and young people and families to develop and improve the children's and neonatal intensive care units. The service responded to patient feedback and told people what they had done in response. They also had been involving patient groups in the development of the vision for the service. Leaders told us they had plans to introduce more patient representatives to improvement groups.

The service engaged with their staff. Staff told us they felt able to speak up about their concerns and that they were listened to. Leaders produced a monthly newsletter to update staff on improvements and to promote good practice.

The service collaborated with their partner organisations to help improve services for patients. Managers and senior nurses exchanged learning and held regular meetings with their regions network of children's health care services.

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

Learning, continuous improvement and innovation

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

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

The service recognised and rewarded staff for innovations and quality improvements. Staff were rewarded by a system the service called 'mugging' because staff were given a mug with treats within it.

Staff and leaders were committed to continually learning and improving services. All staff and leaders told us incident reporting was encouraged and used to improve the service. The service shared learning on staff notice boards, in newsletters, in emails, in social media groups and weekly messages during handover. The message of the week for the last week in July 2021 was telling staff about ways to improve their communication around the care of children with cystic fibrosis.

From November 2020, the children and young people care group had been piloting an outreach service. Staff in the outreach team supported the department with reviewing babies and initiating discharge therefore enabling staff to discharge neonatal patients earlier with a plan to provide support in the community. The outreach team visited discharged patients at their home within a week of their discharge and additional appointments were booked as

necessary. During the home visits, the outreach team supported babies to transition from bottle to breast feeding, gave parents basic life support training and taught them other forms of basic care such as safely sterilising milk bottles and carrying out observations on their babies. Staff gave us examples of when they had identified patients that needed additional support and were referred to the hospital or other organisations depending on the concern. We saw positive feedback from other health professionals including health visitors, GPs and parents. A business case to make this service substantive had been put in as a result of its success.

The service encouraged participation in research. There were staff with dedicated time to support research which included nursing staff that helped support patients and parents understand if they wanted to participate in a research program. Staff were proud of their contributions to developing the knowledge base of care for children and young people.

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

Outstanding practice

We found the following outstanding practice:

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

Areas for improvement

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

Action the trust SHOULD take to improve:

- The trust should ensure that all staff complete their mandatory training.
- The trust should ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be taken swiftly.
- The trust should ensure that all staff follow their policy for pre-operative fasting.
- The trust should ensure that they have a vision for children and young people's services and a strategy based on this to develop a service that meets the need of their community.
- The trust should consider how to improve children's waiting areas.
- The trust should consider how to improve the number of days the actual number matched the planned number for nurse staffing.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one additional CQC inspector and one specialist advisor with experience in children's and young people's services. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.