University Hospitals Birmingham NHS Foundation Trust

Birmingham Heartlands Hospital

Inspection report

Bordesley Green East
Bordesley Green
Birmingham
B9 5SS
Tel: 0121244200

Date of inspection visit: 7 to 14 December 2022
Date of publication: 19/04/2023

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Birmingham Heartlands Hospital

Inspected but not rated

University Hospitals Birmingham NHS Foundation Trust is one of the largest teaching hospital trusts in England, serving a regional, national, and international population. In September 2016, the trust announced plans to merge with the Heart of England NHS Foundation Trust.

The merger by acquisition took place on 1 April 2018. The combined organisation has a turnover of £1.6 billion and provides acute and community services across four main hospitals:

• The Queen Elizabeth Hospital Birmingham

• Birmingham Heartlands Hospital

• Good Hope Hospital

• Solihull Hospital

The trust also runs Birmingham Chest Clinic, a range of community services and several smaller satellite units, allowing people to be treated as close to home as possible. The trust has 2,366 in-patient beds over 105 wards in addition to 115 Children's beds and 145-day case beds.

The trust operates 7,127 outpatients' and 304 community clinics per week. The trust has over 20,000 members of staff.

We carried out a short noticed unannounced focused inspection of the Medical Assessment Unit as part of the medical care core service on 14 December 2022. We received information of concern about the safety and quality of the service.

Medical Assessment Unit Inspection: Overall service rating: unrated

During the inspection, we focused on our safe and well-led key questions to inspect Ward 22 and Ward 23 of which is the Medical Assessment Unit (MAU) and Same Day Emergency Care (SDEC). This is in the centre block within Birmingham Heartlands Hospital.

We did not have sufficient evidence to rate the overall service.

We rated safe and well led as requires improvement because:

The service did not have enough nursing and support staff to care for patients and keep them safe.

The design of the environment did not follow national guidance and was unsuitable for caring for patients, particularly more complex patients overnight.

The service did not have enough suitable equipment to help them to safely care for patients.

Our findings

The service did not always manage medicines well. Medications were not always administered at the times that had been prescribed.

Lessons learned from incidents were not always shared with the wider team.

Leaders did not always operate effective governance processes throughout the service.

Senior leaders were not always visible and approachable to staff on the wards and MAU.

Senior leaders did not ensure staff felt respected, supported, and valued and understood the service's vision and values, and how to apply them in their work.

However;

Staff had training in key skills, 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 safe care records.

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

Leaders used reliable information systems and supported staff to develop their skills. Leaders were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.

Children's and Young Person's Inspection: Overall service rating: unrated

The children's wards provide care for children and young people up to 16 years of age. The trust managed a large population with 115 children's beds and day care beds.

The paediatric services at the trust include children's wards and the children's assessment unit. The trusts high dependency unit and neonatal services are provided at Birmingham Heartlands Hospital and Good Hope Hospital. Outpatient services for children and young people are also provided at Birmingham Heartlands Hospital and Solihull Hospital.

The hospital was the centre providing community paediatric services across the trust. The community service provides support for children who care for children with a learning disability and attention deficit hyperactivity disorder, as well as school nursing and community nursing input.

The service had ongoing challenges due to an increased flow of children across all wards.

We carried out an unannounced focused inspection of children and young people's services at Birmingham Heartlands Hospital on 7 December 2022. This was conducted as we received information of concern about the safety and quality of the service.

We did not have sufficient evidence to rate the overall service.

Our findings

We rated safe as requires improvement and well led as good because:

The service did not always have enough nursing staff with staffing levels regularly below planned levels to care for children and young people. This impacted the morale of some nursing staff.

The service did not always ensure equipment was safely stored.

The service did not always ensure personal protective equipment was worn in line with trust policies and guidance to prevent infections within clinical areas.

The service did not always ensure cleaning records on ward 15 were kept up to date.

The service did not always ensure medicines and controlled drugs were stored and disposed of safely within the high dependency unit.

However:

The service had enough medical staff. Staff mostly 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 prescribed, administered and recorded medicines well. The service managed safety incidents well and learned lessons from them.

Staff provided good care and treatment to children and young people. Staff worked well together for the benefit of children and young people and advised them and their families on how to remain safe.

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.

Medical care (including older people's care)

Inspected but not rated

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. However, there were a number of training modules which had compliance rates below the trust target.

The mandatory training was comprehensive and met the needs of patients and staff. In December 2022, there was an overall compliance rate for all staff of 88.6% which was below the trust target of 90%.

Some staff have not received and kept up to date with mandatory training.

Conflict resolution training compliance was 84%, fire safety training had been completed by only 68% of staff and only 67% of staff had completed governance training. The lack of staff training in key areas such as fire safety may mean staff do not take appropriate action in the event of an emergency or are unclear about the trust's procedures in the event of a fire.

We requested information about mandatory training compliance to dementia awareness and learning disabilities. The data we received related only to health care assistants and did not include other nursing and medical staff. Out of 10 health care assistants the data reflected 4 had completed learning disability training and only 3 had completed training in dementia awareness. A lack of staff training and knowledge may mean that staff may not fully understand the needs of patients living with a learning disability or those living with dementia and may not support them appropriately.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific to their role in how to recognise and report abuse. Staff were required to complete safeguarding adults and children training (level 1 and 2), as well as separate PREVENT and Mental Capacity Act training. The training compliance rates for November 2022 for the staff was 85% for safeguarding level 2 for children and adults. The compliance rate for level 1 children and adults safeguarding was 99%. The trust target was 90%

The overall percentage of staff that completed PREVENT training was 81%, which was below the trust target of 90%. Prevent is one part of the government's overall counter-terrorism strategy, to tackle the causes of radicalisation and respond to the ideological challenge of terrorism.

Medical care (including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to identify, and report safeguarding concerns and worked with other agencies to ensure patients were kept safe. This was evidenced within the patient's records.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff understood safeguarding and how to report safeguarding concerns and make referrals. However, staff stated they were not always well supported by their managers to complete safeguarding referrals. For example, a staff member had a safeguarding concern relating to a patient, when they requested support from their managers, no support to complete the form was given.

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.

Ward areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained.

The medical assessment unit had its own dedicated team of housekeeping staff who kept the unit clean. There were housekeeping staff available on the ward throughout the day to undertake normal and deep cleaning when required. Housekeeping staff were also available during the night to provide additional cleaning when required. All beds spaces were cleaned when patients were discharged to ensure the area was clean for the next patient.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The trust had regular infection prevention control audits. Areas were either rated red (lowest scores requiring action), amber (some improvements required) or green (indicating standards were met). The house keeping supervisor visited the wards and completed daily checks and weekly audits. They would highlight any areas than needed additional cleaning and arrange for staff to action this.

Staff followed infection control principles including the use of personal protective equipment (PPE). During the inspection, the inspection team witnessed that all staff were wearing appropriate PPE suitable for the tasks they were completing, this included aprons and gloves when required.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment were not suitable to keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment did not follow national guidance.

The MAU had previously been two separate wards (Wards 22 and 23) each having 4 patient bays accommodating 5 patients, with a toilet and shower in each bay and side wards which also had toilet and shower facilities. The MAU had recently been expanded due to an increase in patient activity into the emergency department to include other areas which had not previously accommodated patients overnight.

Current arrangements did not meet best practice guidance identified within NHS England's Delivering same sex accommodation published September 2019. There were no toilet or shower facilities in 1 area for the 9 female patients. We found mix sex breaches occurred in the 9 bedded female bay, this was due to the female patients walking through the male's bay. This was causing some associated privacy and dignity concerns as there were no dedicated shower and

toilet areas specifically for these patients. Some patients may stay in this area for over 48 hours. These patients had to either leave the ward and go into the next department (the frail elderly assessment unit) or go through to the next bay which was a male bay to use bathroom facilities. Staff told us that they could not always meet the needs of patients in this environment which was a risk particularly for the more complex patients being cared for in this area.

The service provided data that MAU could safely accommodate a maximum of 58 patients. Between October and November 2022, MAU had accommodated 65 patients and in January 2023 this increased to 64 patients. SDEC was only open between 8am and 10pm. When SDEC closed, patients who had not been seen were moved to MAU to wait on a trolley, this meant that patients wait to be reviewed were further extended. This posed an increased risk particularly to patients with complex needs as they may not receive appropriate care in a timely way.

The service had a suitable and up to date fire risk assessment. During the inspection, all fire exits were clear of blockages and accessible if a fire were to occur.

Equipment was not always stored appropriately. During the inspection we saw oxygen cylinders were being inappropriately stored in an area which had previously been a patient's bathroom. This was also not locked and there was no signage to identify that oxygen was being stored in this room. This was raised whilst the inspection team were on site and the trust rectified in a timely way.

The service did not have enough suitable equipment to help staff to safely care for patients.

The 5 bedded bay in the additional area, which had been converted from a gym area to a patient bay, was used as a corridor for staff, visitors, and patients to access the female inpatient area. This bay was dark with poor natural light. Beds were not available in the new areas and patients were accommodated on trolleys. We found patients, many who were frail and elderly, were staying in this area much longer than the few hours the service had initially planned, with most patients at the time of our inspection stating they had been on a trolley for more than 2 days.

Patients were not moved from MAU in accordance within the enabling emergency flow standard operating procedure (SOP). This stated every hour between 8am and 8pm, 2 patients from MAU should be transferred to a ward. For example, between September and November 2022 there were increased incidents of patients remaining on trolleys from between 26 hours, up to 50 hours, due to there not being enough beds on the MAU. This was further impacted by lack beds elsewhere within the hospital to move patients to. The trust had a business case that requested move beds to be purchased. The SOP did not specify the maximum length of stay for patients in the MAU.

The trolleys did not have pressure relief mattresses to appropriately support patients with pressure ulcers or to prevent pressure ulcers from occurring. During the inspection it was identified that 1 patient’s pressure ulcers had deteriorated as they were on a trolley for 4 days and identified at been at high risk of pressure ulcers.

Within MAU there were areas that did not have oxygen or suction equipment based at each bed space and the staff had to leave the area to collect these machines from another part of the MAU. The lack of piped oxygen supply at each bed space may increase the risk to patients if their condition deteriorated. The ward did have access to portable cylinders however, this was not enough for the number of patients on the wards. The trust had completed a risk assessment for this on 21 December 2022 and were waiting for this to be approved. This included plans for more complex patient’s that require regular oxygen or high dependency to not be accommodated in this area.

Patients could reach call bells and staff responded when called.

Medical care (including older people's care)

During the inspection, call bells were answered in a timely manner. The trust did not complete call bell audits however, patients said staff answered call bells quickly.

Staff disposed of clinical waste safely. MAU had appropriate facilities for storage and disposal of household and clinical waste. However, there were 3 sharps bins which did not have a date of opening recorded in line with the trust policy.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The trust used the National Early Warning Score 2 (NEWS2) to identify patients at risk of deterioration. The hospital used an electronic record which alerted doctors and nurses of an increase in the NEWS. Patients records we reviewed confirmed actions were taken in a timely way following identified patient deterioration. During the inspection we looked at 18 patient records and NEWS were documented in all records and when necessary, they were acted upon according to risk.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed risk assessments and reviewed these; this was evidenced within the patient's records. For example, on the day of the inspection 2 patients required 1:1 support and this was provided; 1 patient received the 1:1 care from their care facility and 1 patient received 1:1 support from the staff on the ward.

During the inspection, staff told us they felt the push model; which is a system used to move patients from the emergency department to the wards to ensure ambulances can offload patients supporting patients through the hospital and to be able to free bed spaces within the wards was not working, as patients were spending more time in the MAU. In the 9 bedded female area and 5 bedded male trolley area, staff were struggling particularly to get patients who were confused and elderly moved to the wards. The staff told us that wards were selecting fewer complex patients which meant some complex patients were staying on trolleys for a long time. Staff sometimes struggled to meet the needs of patients in this environment, which was a risk. This is reflected in that there were, at times, more patients on the wards than there were spaces and also due to not having enough staff on shifts to cover the care of patients.

Staff knew about and dealt with any specific risk issues. During the inspection, there was evidence within the 18 patients records we reviewed that specific risks were identified. This included risk assessments relating to venous thromboembolism, which identified when patients were at an increased risk of their blood clotting and strokes/heart attacks and falls. Staff reported they were not always supported by senior staff, particularly when they needed help to look after patients who may be at a risk of falling. An example of this is that staff had to deal with medication whilst in the bays so they do not have to leave as this would mean that the bays would be left unsupervised.

The service had 24-hour access to mental health liaison and specialist mental health support. The service had access to trained mental health nurses and trained learning disabilities nurses to be able to support patients who may be vulnerable whilst staying on the MAU.

The service also had access to psychiatrists and phycologists. This was evidenced within patients records as requests were made to support patients with mental health concerns within the MAU.

Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards which was evidenced within the patients' care plans.

Medical care (including older people's care)

Nurse staffing

The service did not have enough nursing 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. Managers regularly reviewed and adjusted staffing levels and skill mix, however they were not always able to amend staffing levels to meet the needs of the patients in the MAU. Bank and agency staff received a full induction.

The service did not have enough nursing and support staff to keep patients safe. Staff told us that they were unable to leave patient bays as there were not enough staff, particularly at night. This would leave the bay unsupervised, and patients would be at risk of falls or harm. Data confirmed staffing fill rates were below the required staffing levels. Between September and November 2022 staffing fill rates for the MAU trolley area for registered and unregistered staff were 59%, 41% and 34%. Between September and December 2022 staffing fill rates for wards 22 and 23 for registered and unregistered staff were 56%, 63% and 69%.

Staff told us that there were greater concerns about insufficient staff on night duty and particularly when the SDEC unit closed. This was due to SDEC closing at 10pm and all patients there would be moved to MAU.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The service had a procedure and process for reviewing the required nursing staffing levels according to patient needs. This defined what interventions were to be implemented in response. Due to the staffing pressures, the number of nurses and healthcare assistants rarely matched the planned numbers. Staff escalated to senior staff when staffing levels were low. Between October and December 2022, there had been 1,015 unfilled shifts that had needed to be covered on wards 22 and 23. The main reason for this lack of staff was due to vacancies and sickness and the need for additional staffing cover to support complex patients.

The ward manager could adjust staffing levels daily according to the needs of patients. Between October and December 2022 senior staff had increased staffing levels on several occasions where they had identified this was needed.

In December 2022, the service had 39.54% staff vacancy rates for band 6, 7 and 8 nurses. Recruitment for these posts was ongoing at the time of the inspection. However, the high vacancy rate had impacted on the quality-of-care patients received, as well as on staff morale.

In December 2022, the service had 30% of staff vacancies for healthcare assistants. The service had 10 healthcare assistances that worked across the wards.

The service had 13.49% of staff turnover rates in December 2022.

The service had reduced sickness rates from the previous month of October 2022 at 7.34% to 6.14% for November 2022.

MAU and the wards relied on the use of bank and agency staff. This was due to the staffing vacancies. However, staff told us that managers tried to keep consistency by using the same bank and agency staff who were familiar with the service.

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

Agency staff who consistently worked at the service were included in the trust training plan and attended trust training.

Medical staffing

Medical care (including older people's care)

The service 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 and adjusted medical staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. During the inspection, we were told that Wards 22 and 23 were covered by 2 consultants. During the day they covered from 8am to 4pm. There was also 1 consultant working 3pm to 10pm and 1 consultant working 4pm to 10pm. Consultants were supported by a team of registrars and junior doctors.

The service had a low vacancy rate for medical staff. The service currently had 4 substantive consultant vacancies. Vacant consultant shifts were covered by bank consultants or locums. The service did not have any vacancies for junior doctors.

The divisional meeting recorded on Thursday 8 September 2022 that the trust was recruiting for middle grade doctors.

The service had low rates of bank and locum staff. The service used regular bank and locum staff and block booked staff to ensure that the service had enough doctors to cover the shifts 7 days a week.

Managers could access locums when they needed additional medical staff.

The service had access to regular locums and every morning this was assessed by the division 3 senior management team and the medical director. The requirement to use locums was dependent on the pressures within the trust and if required, locums could be moved between sites to ensure there was enough consultant cover.

Managers made sure locums had a full induction to the service before they started work. Doctors who regularly supported the service were able to attend training.

The service always had a consultant on call during evenings and weekends. The MAU had adequate on call consultant cover, this included nights and weekends.

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. All patients' notes were comprehensive, and information was well documented. If a patient required additional support from another team, such as the mental health team, pharmacy, or psychologists, staff clearly documented this.

All patient records were clearly signed by staff, dated and timed, so when entries were made it was clear when they were completed.

Records were stored securely. All patient records reviewed during the inspection were electronic and these were stored on a password protected patient record system for security purposes.

Medicines

Medical care (including older people's care)

The service mostly used systems and processes to safely prescribe, administer, and record medicines. Medicines were safely stored. However, the levels of missed antimicrobial medicines did not meet the trust target.

Staff did not always follow systems and processes to prescribe and administer medicines safely.

The service used a Prescribing Information and Communication System (PICS) which is an electronic prescribing system patients' medication.

Dates and times of medicine administrations were recorded on PICS. It also ensured that any late or missed doses of medicines were easily identified. The specialist pharmacist reviewed this daily. They identified the reason why the medicine was not given or why it was not recorded. Any learning was shared with the staff team.

Pharmacy vacancies had been identified on the services risk register. There are national difficulties in recruiting hospital pharmacists. Despite this, the pharmacy team had a presence on the MAU to review medications.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were pre-packed for patients on discharge from the service.

Staff completed medicines records and mostly kept them up to date.

During the inspection it was evidenced in patients records that antibiotics were not always given at the prescribed times, particularly at night. For example, for 1 set of antibiotics, the time recorded for administering of medication was recorded as 10am.

For example, 1 patient was prescribed an antibiotic to be administered at 10am, however, they were given to the patient at 5.55am which was 4 hours too early, and medication instructions were not followed.

The service had a 2% target for missed antimicrobials. However, in November 2022, this was worse than the trust target at 8.6%. This meant that there was a delay in administering antibiotics to patients, which could mean antibiotics may not be effective and patients were at increased risk of further infection and deterioration.

Staff stored and managed all medicines and prescribing documents safely. All medications were securely stored, and all medications rooms were clean and tidy.

Incidents

Staff recognised and reported incidents and near misses. However, managers investigated incidents but did not share lessons learned with the whole team.

All staff knew what incidents to report and how to report them. This was evidenced in completed incident reports on the trust's electronic records system.

Between June and October 2022 on Wards 22 and 23 there was an overall increase of incidents. These included falls, pressure ulcers and medication errors.

Medical care (including older people's care)

Between September and November 2022 on Wards 22 and 23 there was a clear theme of an increase in the number of incidents raised relating to patients waiting on trolleys as 21 incidents had been reported.

A weekly preventing harm forum was held to discuss incident reports, learning from incidents and to ensure the learning was shared and changes quickly implemented.

Staff did not receive feedback from the investigation of incidents, both internal and external, to the service. Staff told us that they do not receive any feedback about incidents they raised. This contributed to the problems of learning from incidents to prevent recurrence.

Safety huddles took place twice daily at 7am and 7pm and were led by the band 7 nurse. Staff told us safety huddles discussed patients care and when any improvements were needed.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, senior leaders were not visible and approachable in the service for patients and staff.

The senior leadership team for division 2 and division 3 included a medical director, managing director, two directors of nursing, two directors of operations and 2 deputy directors of nursing.

Band 7 nurses would take responsibility of the shifts.

Staff felt supported by the local managers on the wards and there was an open-door policy. However, staff felt that there were challenges to gaining support from senior managers to support the wards to be able to make required changes. Staff told us each department was working individually to implement the new ways of working including the new push pathway model, rather than working collectively together. This was evidenced by more complex patients remaining on the MAU for longer periods of time as patients with less complex needs were being moved up to the wards more quickly.

Vision and Strategy

The service had a vision for what it wanted to achieve. However, staff were unclear how the vision and strategy directly applied to them and their roles.

The trust has a vision and strategy. The leadership team for the MAU had identified areas from the strategy they needed to work on and monitored progress against this at divisional governance meetings. These included to ensure that patient's experience continually improved and to ensure they continued to develop staff and build on staff confidence to ensure they had the skills to provide high quality patient care.

The service was also looking at accessibility of care for patients and ensuring that patients were supported in the most suitable areas to support them to gaining the correct care for their needs.

The service continued to develop business cases for the next 2 years to help develop the service. For example, one business case was to make more permanent facilities including toilets and showers. Another to change the provision from trollies to beds.

However, staff were unclear about the vision and strategy and felt decisions were made without adequate consultation. For example, changes to the provisions of the MAU which included additional bed spaces in areas which had not previously accommodated patients overnight.

Culture

Staff did not always feel respected, supported, and valued by their senior managers and this was impacting on the morale within the service. However, all staff without exception were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Staff told us that regularly having low staffing levels on shift had significantly affected their morale. Staff sometimes felt stressed by the complex nature of the care required by some patients on Ward 22 and Ward 23, due to feeling they could not meet their needs in the MAU environment due to not having enough staff and with some of the areas being unsuitable to care, particularly for more complex patients

Before the inspection, we had received concerns from whistle-blower's that stated they were concerned about the staffing levels and culture within the service.

During the inspection, staff told us that within the Wards they felt well supported by local managers, and that they worked together as a team. We saw examples of consultants taking time to share learning and knowledge to other staff.

The service had a workforce strategy team that looked at the workforce and different ideas of how to recruit staff and how their recruitment events were delivered to recruit from the diverse local community to ensure their workforce reflected the local population.

Staff stated they were given career development opportunities. The trust’s workforce team were focusing with the service to develop international recruits and support staff to gain promotions.

Governance

Leaders did not always operate effective governance processes throughout the service.

During the inspection period we requested minutes of meetings where concerns have been raised relating to the overcrowding of the MAU. However, the service could not provide meeting minutes where this has been discussed and recorded. This meant there may not be enough oversight by senior leaders of the main challenges within MAU and regular monitoring of required actions needed to address these concerns.

Information systems did not adequately support the leaders to identify patients on trolleys for an extended period and may put patients at increased risk of harm.

The service had not met the trust target for missed antibiotics and no information was provided to identify how they were addressing this.

The leadership and governance processes had not recognised the mixed sex breaches we identified during the inspection regarding suitable toilet and bathing facilities for patients staying within the MAU overnight. In addition, we did not receive any evidence that the service were already aware of the concerns we identified around more complex patients not always being moved to ward areas as quickly as possible.

Management of risk, issues, and performance

Leaders and teams did not use systems to manage performance effectively. Risks were not adequately identified and escalated to reduce their impact.

The trust had several dashboards of information around the performance of the service.

The clinical dashboard provided detailed trust wide performance. However, we were told, data specific to MAU was available within the dashboard. This meant potential risks around performance specifically in MAU could be identified, for example the completion of patient assessments observations, pain reviews and nutritional risk assessments.

The patient experience dashboard provided by the trust identified there had been 9 complaints, 26 concerns and 1 Friends and Family Test response since April 2021.

The trust had recently appointed a new governance lead, to be able to review incident reports. Following their reviews, they passed on information to the director of nursing. The service had recently started to collate data to enable them to identify any actions and learning from this.

Red flags that were put into place once any themes of incidents are identified, were discussed in during monthly meetings with divisional 3 senior leaders and throughout the day. These fed into the governance meetings.

The service had a risk register and ward managers, and the senior leadership team were aware of what their top risks were. This included lack of equipment in the MAU, lack of pressure mattresses and the extended lengths of time some patients remained on trollies for (up to 50 hours) without pressure relief. This increased the risk of patients acquiring pressure ulcers, especially with elderly frail patients. The other main risk was relating to staff vacancies, which was impacting on the ability for staff to provide safe care and treatment. This was supported by the amount of falls that staff were reporting for the MAU.

The senior team acknowledged that staffing was one of their biggest challenges and were working to fill vacancies. They also acknowledged what the staff have achieved despite the challenges and how well they have responded to difficult circumstances.

Senior managers held quality and safety board meetings where risk and safety were discussed; actions were put into place to address the risks.

The service held site meetings 3 times a day on each site within the trust to discuss current pressures. This enabled senior staff to escalate and address any concerns that had been raised so that support could be provided to mitigate any identified risks.

Medical care (including older people's care)

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.

The service had recently begun to collect specific data relating to the overcrowding of the MAU. This had recently started and was discussed in the Supportive Improvement Programme led by head of clinical governance and patient safety. The data stated the number of patients that were moved from the same day emergency unit, leading to additional patients on MAU and this then prompted the senior leader team to request additional staffing.

The service used electronic patients records to safely store all information relating to patients care and treatment. All staff could easily access these records to ensure they were safely supporting each patient as much as possible.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Staff had stated that the “Push Model” had taken time to embed, and senior leaders were working to change the culture regarding this and ensuring that all patient's journeys were most appropriate for their needs.

The service looked at diverse ways they could support international recruitment and were working with the rest of the trust to achieve this. They were also reviewing how they could support the learning and development needs of individual staff and provide specific training to support them to work in a ward environment.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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 service MUST take to improve: We told the service that it must take action to bring services into line with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action the trust MUST take to improve:

- The trust must ensure that all equipment used by staff to provide care or treatment to patients is used safely. (Regulation 12 (2d), Safe care and treatment).
- The trust must ensure that staff have enough equipment to meet patient’s needs (Regulation 12 (2e) Safe care and treatment).
- The trust must ensure the premises and environment are suitable for staff to provide safe overnight care for patients for sustained periods in the Medical Assessment Unit. (Regulation 15 (1c) Premises and equipment).
- The trust must ensure that the service has enough numbers of staff to always provide safe care and treatment to patients. (Regulation 18 (1) Staffing).

Medical care (including older people's care)

Action the service SHOULD take to improve: We told the service that it should act because it was not doing something required by a regulation, but it would be disproportioned to find a breach of regulation overall.

Action the trust SHOULD take to improve:

- The trust should ensure action is taken to avoid mixed sex breaches. (Regulation 10, Dignity, and respect)
- The trust should ensure that staff are receiving support to complete safeguarding referrals to ensure patients are safeguarded from harm and abuse. (Regulation 13, Safeguarding)
- The trust should ensure that staff administer medicines at the times prescribed. (Regulation 12, Safe care, and treatment)
- The trust should ensure that senior leaders are visible and approachable to staff on the wards and Medical Assessment Unit. (Regulation 17, Good governance)
- The trust should ensure staff feel respected, supported, and valued by senior leaders. (Regulation 17, Good governance)
- The trust should ensure that staff close sharp bins to prevent people accessing them. (Regulation 15, Premises, and equipment)
- The trust should ensure that staff store oxygen in locked storage to prevent people accessing them. (Regulation 12, Safe care, and treatment)

Services for children and young people

Inspected but not rated

Is the service safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff however, not all medical staff had completed it.

Nursing staff received and kept up to date with their mandatory training.

For November 2022, overall nursing training compliance rates for the division was above the trust target of 90% at 91%, with resuscitation awareness training at 98% compliance.

The education compliance team monitored training compliance levels each month to ensure training figures met the trust target of 90%. Staff had been unable to attend some training sessions due to the increased flow of children and admissions into the department and due to nursing staffing gaps. The trust recognised this and had an action plan for both training and recruitment, to address this. The trust paid additional hours to complete training, this was monitored on a one-to-one basis to meet the trust target for some modules.

All medical staff received but were not always up to date with all their mandatory training. An overall training compliance of 81% was achieved for medical staff across all modules. Leaders monitored training each month with the aim to meet the trust target of 90% across all modules and grades for medical staff.

The mandatory training was comprehensive and met the needs of children, young people and staff. Clinical staff completed training on recognising and responding to children and young people with mental health needs, a learning disability and autism. Managers monitored all mandatory training monthly and alerted individual staff through emails when they needed to update their 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.

All staff received training specific for their role on how to recognise and report abuse. Staff were able to give examples of types of safeguarding concerns they would report and understood how to protect patients from abuse.

All staff who were directly caring for children were required to complete level 3 adults and children safeguarding training as a minimum, in line with the trust's policy. For November 2022, adults and children safeguarding training levels were

either above, met or just below the trust target of 90%. Level 1 training compliance was at 98%, safeguarding adults and children level 2 compliance was at 89% and safeguarding children level 3 compliance was at 92% which was above the trust's target. The trust was working hard to improve training levels when they were below the trust target to ensure all staff met this on a monthly basis and remained up to date with this training.

Safeguarding leads monitored training and safeguarding activity. Senior staff and the specialist mental health team were responsible for supporting staff to care for children living with a mental health condition. The service was working towards providing training to staff in the Mental Health Act by April 2023.

Not all medical staff had completed all required training specific for their role on how to recognise and report abuse. Overall compliance rates for November 2022 for safeguarding adults and children level 1 training was 100% for consultants and registrars. However, safeguarding adults and children level 2 compliance rates for consultants was below the trust target at 74% compliance. Consultant compliance with level 3 adult safeguarding was 61% and children level 3 was 91% which was above trust target. Staff availability to attend training sessions was impacted by staffing difficulties and the increased number of admissions of children into the department. The service had an action plan to monitor safeguarding training rates with the aim of improving compliance rates. Leaders monitored training compliance each month. Local teams were supported by the trusts safeguarding team for advice with access to a single point of contact to mitigate risk and seek advice where they had safeguarding concerns for children.

Medical staff received safeguarding supervision to help them to keep children safe and were supported to do this. The safeguarding team offered safeguarding supervision to all staff this included on an individual basis and a regular quarterly session. We saw actions addressed were clear with accountability placed back onto staff to promote their own learning and understanding of the necessary safeguarding actions to be undertaken.

The trust safeguarding team had recently been restructured to include the children services team and vulnerabilities team to further strengthen safeguarding support for leaders and staff.

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. Staff knew how to protect children, for example if a staff witnessed inappropriate behaviours from a person towards a child, they would raise this immediately in line with the trust policy.

The trust used a wellbeing passport for children and young people with mental health concerns and a learning disability passport to capture the key information about a child and their social history. This enabled the trust to capture concerns during admission to keep children safe.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The education team shared learning regarding children's vulnerability to abuse and neglect particularly for those with a mental health condition or a disability. All paediatrics staff received specific training in mental health provided in collaboration with a local Child and Adolescent Mental Health Services.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff made effective quality referrals and contacted the safeguarding team if support was required. Staff ensured safeguarding referrals were referred to the correct local authority without delay to help keep children safe. The children's services department had effective administrative support to process a safeguarding referral. The trust's electronic patient record system had flags

to alert staff when there were safeguarding concerns. Staff could easily access the safeguarding team for advice or support with a dedicated a single point of contact telephone line. The trust recognised safeguarding training needed to be strengthened. They were working towards introducing mandatory level three safeguarding training across all grades of staff providing patient care to be implemented from April 2023.

Staff followed safe procedures for children visiting the ward. Staff used a swipe card to enter children's wards and monitored visitors through the intercom system. Staff on all wards monitored when parents and families were visiting. Staff kept outdoor areas secure for children and we were told children were supervised when undertaking any outdoor activities with the therapy team. The trust had absconding and safeguarding policies for staff to follow to safeguard children on wards.

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. We inspected Wards 14, 15 and 16, the Paediatric Assessment Unit (PAU), Neonatal Unit, High Dependency Unit (HDU) and children's outpatients and found all areas including patient bays, bathrooms and triage rooms were visibly clean. The housekeeping team consistently worked on the paediatric wards were aware of their responsibilities.

Staff used an isolation precaution sign on all wards to indicate when children were admitted with an infection. This reminded staff to use the correct personal protective equipment and protocols were displayed.

The service generally performed well for cleanliness. Infection prevention control audits completed for the environment across all children's wards and the Neonatal Unit scored 100% in November 2022. Hand hygiene audits for November 2022 were 100% across all departments and wards within children services. Children services reported no infections, C difficile or any blood stream infections within the last 3 months.

However, between August and October 2022, the neonatal ward had scored below the 100% target, but this had improved in November 2022 to 92%. The trust's infection prevention and control lead supported the service where improvements in infection prevention and control were identified from audits with the aim of improving performance with cleanliness.

Most cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. However, the cleaning record for ward 15 had not been completed for 5 and 6 of December 2022. Following the inspection, the trust provided evidence of actions leaders had taken to remind all staff to complete records and to ensure that to prevent reoccurrences.

Staff did not always comply with infection control principles including the use of personal protective equipment. We saw 4 staff members wore masks below their nose on Ward 16 which included when entering clinical areas which posed potential infection risks to patients and staff. We escalated this during inspection to the trust's senior leadership team. In response, the trust reminded staff through written communication to always follow infection prevention control measures across all wards.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw equipment being wiped clean and labelled after use.

Environment and equipment

The design, maintenance, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, children and their families did not always have easy access to working call bells.

Staff responded quickly to call bells. However, we saw 2 children and their families who did not have working call bells on Ward 16. We informed the trust following the inspection and the service implemented a daily check to ensure call bells were working. Senior staff also emailed staff and discussed this with staff during daily handovers to remind them of the importance of checking. A parent and their child informed us nurses always responded when they required attention from a member of staff.

The design of the environment followed national guidance. However, there was limited space due to the age of the building, particularly in the Paediatric Assessment Unit, Wards 14,15,16 and the High Dependency Unit. The children's outpatient's department required some improvements to the environment to meet the needs for children and young people. Refurbishment of the children's services was in progress which was outlined in the trust's 3-year plan for 2021 – 2024.

The space constraints caused additional challenges to staff especially as the number of children's admissions into the service had significantly increased. Despite this, staff used the available space in the safest way possible and areas were tailored to children's needs. Wards were designed specifically and tailored to meet the needs of children and young people. They had brightly coloured decoration and signs suitable for children.

During the COVID-19 pandemic, the trust changed policies to comply with COVID-19 infection prevention control guidance which meant staff had to remove children's toys and magazines. The team was working hard to resume to how it was before the pandemic as they knew the importance ensuring the environment best met the needs of children.

Staff carried out daily safety checks of specialist equipment. We saw staff were checking equipment before use. Staff were aware of the process to report and escalate concerns when equipment was not working. The majority of resuscitation trolley daily checks were completed for November 2022. However, there were two days where staff had not recorded they had conducted the checks.. Leaders had acted to prevent recurrence and mitigate the associated risks of emergency equipment not being ready and safe for use during an emergency.

The service used the facilities available to best meet the needs of children and their families. The trust recognised the challenges to the environment and were proactively looking at ways to improve the environment of the service. Staff arranged for parents to stay with their children and had access to a family room during visits.

The service had enough suitable equipment to help them to safely care for children and young people. Staff informed us they had slide sheets, hoists, bed pan washers and bathing facilities for children who needed them.

We saw a dedicated resuscitation room on the Paediatric Assessment Unit which was equipped to monitor and assess children who arrived critically ill.

Staff disposed of clinical waste safely. We saw staff disposed of waste safely. Sharp bins were available in all clinical areas and staff used them safely on all wards and units.

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. There was evidence of accessible, up-to-date protocols and guidance for resuscitation, anaphylaxis and sepsis management. Staff were able to explain to us what they would do if a child deteriorated and showed signs of sepsis.

Staff followed national guidance by using the paediatric early warning system (PEWS). Staff were very familiar with the PEWS, and it was used to support the identification of children who were at risk of deteriorating. This was linked to an escalation protocol which identified actions to be taken if the PEWS was elevated. Following the inspection, we reviewed PEWS audits across children services for May to October 2022. The trust maintained an average of 96% to 100% compliance score. Minutes from monthly divisional assurance meetings outlined what improvements were required and learning was shared effectively with the wider team. Records showed consultants reviewed children following concerns identified from PEWS if required.

Children who were at risk of deterioration were transferred to the High Dependency Unit (HDU). The unit was appropriately staffed by 1 nurse to 2 patients in line with national guidance. A centralised monitoring system was installed in the HDU bay to monitor children and young people. During the inspection, we saw 1 child who was deteriorating in HDU. Senior staff responded quickly with the support from the critical care outreach team and members of the trust's resuscitation team. The atmosphere was calm and there was a real sense of teamwork. The child was monitored closely, and safe practice was seen whilst the child was intubated (the placing of a breathing tube so the child could be supported on a ventilator). There was a well-established process for contacting the local retrieval team (KIDS) and the child was safely transferred to a paediatric intensive care unit within a few hours.

The service had a rapid response team to care for children in the community with acute conditions. Clinical practitioners could treat conditions such as viral illness, urinary tract infections or any conditions which could be treated safely in a community setting. The service had implemented this pathway to support children to stay at home and prevent hospital admissions. A matron from the community team came into the hospital twice per week and worked clinical shifts on wards and in roles where they were most needed to support children services. This supported communication and teamworking and ensured the child's discharge was much smoother. The community team had recently expanded their nursing team from 2 staff to 3, which allowed them to provide the service 7 days per week from 6.30am to 5pm.

The trust had an appropriate pathway for children requiring a surgical procedure. A child was admitted to ward 14 following a pre-screening assessment and then transferred to theatre. Following surgical procedures and recovery the child was returned to ward 14. Most staff were trained in European Paediatric Advanced Life Support (EPALS) and Paediatric Immediate Life Support (PILS). The trust reported 93% of staff had completed both EPALS and PILS training to care for children across surgery and paediatrics.

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. We saw patient notes were completed in detail including a full admission assessment as part of a patient care plan including risks such as choking, flags on records relating to risks and

pain. Staff within the neonatal unit used a sepsis risk calculator to assess if well babies met the criteria for early treatment. All patients' notes contained a detailed treatment plan and were signed off by a clinician. In paediatrics, clinical staff used the sepsis bundle to determine signs of sepsis. Nurses were aware of signs of deterioration and the need for antibiotics to be administered to children and young people within 1 hour.

Staff knew about and dealt with any specific risk issues. Staff recognised risks of, falls, choking and reported them appropriately. Staff were able to easily access guidance and flow charts in clinical areas and seek support from clinical staff.

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 within children services were able to refer children for psychiatric review and advice from a mental health specialist. Staff completed a pre-assessment and a passport with key information to identify the level of risk and harm following admission.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. For the reporting period November 2021 to November 2022, there had been patients admitted to the service who required transfer to a mental health We saw a child and young person's enhanced care bundle was being used within children services for children under the age of 16 presenting with difficult behaviours. Children were assessed for the level of risk of self-harm or suicide. Appropriate levels of support were provided dependent on the levels of risk. For example, if a child was at a high risk, staff provided 1 to 1 supervision. The staff were able to access the trust's security staff for support if a child became aggressive or violent.

Staff were able to care for children with vulnerabilities in line with the trust policy. This fed into the trust vulnerabilities strategic steering group for monitoring and governance. Ward staff were able to seek advice from mental health professionals and refer children for further psychiatric review if they became a risk to others or themselves, in line with the trust policy. Staff completed a therapeutic observation including an engagement risk assessment and a specific mental health care plan. Staff were able to call an emergency security number if a child was at immediate risk to de-escalate situation in line with trusts restraint policy. Security staff would attend if support was required on the ward.

The trust worked in line with restraint policy and took consent from families and parents' prior restraining a child under the age of 16. The senior team had learned from a recent case where a child was restrained in the department. They jointly worked with an external agency to improve their restraining practices for children with mental health concerns. Following discharge, the service handed children's care over to the community mental health team to maintain their safe care.

Staff shared key information to keep children, young people, and their families safe when handing over their care to others. Nurses facilitated early discharge with home intravenous therapy, injections, and clinical review. Nurses liaised with the medical team to prevent readmissions and re-attendance. The team supported children's and young person's kidney condition cases with a telephone advice service. Key information was shared with parents and community professionals to care for children safely.

Shift changes and handovers included all necessary key information to keep children and young people safe. Staff informed us they were a part of daily handovers and key information of patients risks and conditions were discussed in detail, this included any changes to the child and shared learning.

The trust had developed a health and wellbeing passport used in children services which included information about the care and treatment they had received. The trust had specific tailored passports for children living with a learning

disability and mental health concerns to ensure they received individualised care specific to their needs. Information included their wishes regarding the delivery of their care and individual experiences which were all monitored by staff on an action plan. Parents and children were part of this approach to keep the child at the centre of care. Passports were bright, child friendly and easy read. The trust worked in partnership with a special needs school to develop these passports and to ensure they were easy to read particularly for children living with a learning disability and to enhance the patient experience across all areas where children were cared for. This protected children from the risk of human rights' abuse and prevented discrimination of children with a mental health condition.

The trust used a 'passport for specifically for child' living with a learning disability or mental health condition. The passport included children's preferences, safety concerns and their likes and dislikes. This ensured staff provided individualised support for children and met their needs.

We saw multi-disciplinary meeting minutes held of child and was supported on a 5 to 1 basis awaiting a tier 4 bed within community. Staff took actions to mitigate risk and assessed triggers and were supported by safeguarding lead. The trust had learnt from this, a clear care plan to be in place and pathways of restraint. We a viewed ligature risk assessment, the trust had identified risks for mental health pathway being admitted to hospital and overall risk assessment was in place to mitigate and prevent safety. The trust updated their restraint policy in June 2022. Staff understood working in line with these policies for children with a mental health condition and recently had learned for child with complex mental health concerns.

Nurse staffing

Nursing staff had 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. However, the service did not always have enough nursing staff with staffing levels regularly below planned levels. The low staffing levels in the department were causing significant stress to some staff.

The service did not always meet the planned set number of nursing staff to keep children and young people safe. Data showed between June 2022 and November 2022 the service had nursing staffing fill rates in paediatric outpatients which were much lower than planned levels; ranging from between its lowest levels at 49% in October 2022 to highest levels of 69% in June 2022. Staffing levels in the Paediatric Assessment Unit were also below planned levels over the last 6 months at between 79% and 85% fill rates.

The nursing staffing levels for the community paediatrics nursing team were much lower than planned levels for the last 6 months. This service had not had a Registered Nurse as part of the team since 24 October 2022. Staffing fill rates ranged from 26% in July 2022 to 69% in October 2022.

However, senior leaders assessed the staffing levels daily with their local teams and implemented measures to fill staffing gaps where possible by deploying senior children's services staff to where they were most needed. Senior leaders increased their visibility and worked on supporting the wards to safe care for children. We saw this during inspection of leaders being available across all areas of children services.

The trust had increased the number of registered nurses across wards to manage children's needs safely and were in the process of recruiting additional staff to fill vacancies. During the inspection, the service had a minimum of 2 registered children's nurses per shift in all inpatient and day care areas in line with national guidelines. Service leaders increased their visibility in clinical areas to monitor and support teams to mitigate risks.

Staff felt they required more staff on duty at times. The leadership team were working to address the staffing challenges such as with ongoing recruitment and increasing the visibility of leaders. This also included flexible working, overseas recruitment and increasing the number of trainee nursing associates. Leaders created a positive learning environment and supported trainee nursing associates to 'upskill' to become registered nurses to help to fill gaps in their nursing staffing establishment.

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 worked in line with trust guidelines when the service had nursing staffing levels below planned establishment. The service used higher grade nurses and equipped trainee nursing associates with additional skills to fill gaps in staff skills.

The ward manager was able adjust staffing levels daily according to the needs of children and young people. Leaders assessed the risks and the complexity of all children to safeguard them and ensured there were always safe staffing levels. Leaders monitored activity by deploying higher skilled staff and leaders being more visible across all children services. Senior staff completed rotas in advance to manage staffing shortfalls and inappropriate skill mix.

The service was working hard to reduce the high number of nursing vacancies across children services currently at 41 whole time equivalent roles. The trust used a retention and recruitment action plan to monitor and mitigate risks due to staffing which was recorded on the service's risk register.

The paediatric team had access to a dedicated 'bleep' to manage capacity and flow and to support paediatric nursing daily. Leaders reviewed the PAU risk register and ensured it reflected the risks such as low nursing staffing levels, high levels of admissions and the amount of complex care children required. Leaders monitored these risks on the risk register and worked hard to mitigate identified risks to keep children safe.

Matrons supported clinical shifts when required. Senior leaders were visible across all wards and units if any support was required. Nurse educators provided inductions and training on role specific skills for all staff. They focused on the induction of new starters to ensure they developed skills appropriately and in a timely way. This enabled staff to function safely within their role to care for children. Staff were eager to attend study days and the trust encouraged this. However, these were impacted by the lower levels of staffing and staff being required to work additional clinical shifts.

The departments staffing levels were below planned establishment levels. Senior staff ensured they were deploying staff to areas where they were most needed to ensure there was an appropriate skill mix with band 7 nurses supporting this. The low staffing levels in the department were causing significant stress to some staff particularly as some staff felt it was impacting on their ability to consistency provide the required levels of care to children.

The numbers of healthcare assistants on shifts matched the planned numbers. The service currently had no healthcare assistant vacancies.

Where bank and agency staff were used, they were block booked to maintain consistency and provide high quality and safe care. Managers ensured staff had a full induction and understood the service. The service used known agencies for consistency across all wards.

The service had reduced turnover rates in October 2022 across all staff levels and grades from the previous 3 months to 13%. The trust did not provide their turnover target with the data submitted.

Services for children and young people

Senior leaders were working hard to reduce the November 2022 overall sickness rate of 7.1% for the service with ongoing work to increase the number of staff in the service through ongoing recruitment.

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 trust reported there were no gaps in medical staffing. There were enough medical staff on all wards and staff were able to easily access them. Medical staffing was complaint with national guidance with children seen by a consultant paediatrician within 14 hours of admission as required. Medical staff were visible on all wards.

The medical staffing matched the planned number. The trust reported they had no vacancies for medical staff across children services. Leaders monitored daily medical staffing levels according to patient need to safely care for children and young people.

The service had low turnover rates for medical staff at 6% and monitored the retention and recruitment plan according to the number of admissions. The trust did not provide the trust target for turnover.

Sickness rates for medical staff were reducing and for November 2022, overall long term and short-term sickness rates were at 11%. The trust recognised the need to over recruit to cover sickness and absence and used a detailed action plan to achieve this.

Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and senior leaders reviewed this each day to ensure they had a clear oversight. Medical handovers were held twice every 24 hours led by a consultant paediatrician.

The service always had a consultant on call during evenings and weekends. All consultants were on call. Nurses informed us they had access to a consultant if a child's condition deteriorated. The trust worked in line with the royal college of paediatrics and child health guidance.

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. We viewed 10 paper patient records across Wards 15 and 16. Records were completed in full and had a clear treatment plan, showing involvement of a multi-disciplinary team. They had been checked and signed off by a clinical member of staff. The patient records were well organised and easy to access.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Patient records were stored centrally which meant staff could access them easily.

Records were stored securely and locked across all wards. Staff were aware of the importance of keeping records safe and secure.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, we identified some medicine storage and disposal issues within children services.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 9 patient medicine records and saw that medicines had been prescribed, administered, and recorded in line with trust policies and national guidance. The route of administration was recorded including the reason for prescribing medicines. Patient weights were recorded on all the charts we reviewed. This is particularly important for calculating weight-based medicines prescribed to children and neonates. Staff had recorded allergies on all medicine charts.

The trust had developed an 'Acute Asthma and Wheeze 'medicine administration chart' which helped to record the amount of times children had used the inhaler, especially if it was being used more than 4 times a day, so that their treatment could be reviewed appropriately.

Staff knew who to contact in pharmacy for advice on medicines. There was a dedicated clinical lead pharmacist in paediatrics who regularly visited all the paediatric wards (Monday to Friday) to provide pharmacy support and advice to optimise the use of medicines.

The service had policies and procedures for the safe use of medicines, including specific paediatric guidelines. For example, there were policies for antibiotics, anaphylaxis pathways, asthma treatment, meningitis and sepsis treatments.

A dedicated children's hospital at home team called Paediatric Ambulatory Treatment and Care at Home administered long term antibiotics and growth hormones to children at home. The team were supported by the lead clinical pharmacist who checked each prescription before the treatment.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people, and their carers about their medicines. Staff monitored and reviewed the effects of medicines administered which included close collaboration between pharmacy and the microbiology consultants to ensure antimicrobial guidelines were followed and reviews of antibiotic treatments were undertaken.

Pharmacists reviewed, monitored and provided clinical advice on the best way to administer medicines. For example, the clinical pharmacist provided advice on how to administer a medicine safely through a nasogastric tube. Any advice was written onto the medicine charts as reminders or prompts.

Staff completed medicines records accurately and kept them up to date. Prescription and administration records were managed to ensure that they were accurate, complete, legible, and up to date. This included documenting reasons if a medicine had not been administered which ensured an accurate medicine history was available.

Staff did not always store and manage all medicines and prescribing documents safely. Medicines on wards were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine cupboards were locked and secured however, one cupboard on Ward 15 was overfilled with stock. This made it difficult for staff to easily locate medicines.

Services for children and young people

There was poor medicine storage, medicine preparation and medicine security on the high dependency unit. Although the medicine cupboards were locked, the medicine storage and preparation area were too small and cramped for the safe management and preparation of medicines.

Additionally, medicines were not always stored in their original containers posing a risk of incorrect or out of date medicines being prescribed. We found loose blister strips of medicines which had no expiry dates due to the blisters being cut up. Also due to the lack of suitable storage space, a box of intravenous fluids was stored on a windowsill on the ward. This was not secure or safe. Audits on the safe storage and handling of medicine had identified these medicine storage risks. We received assurance from leaders following our inspection of improvements they were making in the HDU following our feedback and measures they had taken to improve safe storage and practices of staff. The service was reviewing ways to resolve this on a longer-term basis, as the pharmacy team were using a daily checklist and had an action plan to monitor the progress of improvements required. This included increasing staff awareness of their responsibility to ensure medicines were stored securely or disposed of safely following the trust policy.

The risk register included medication error risks due to a lack of adequate funded pharmacy support and challenges with the environment. Actions in response included increasing the staffing provision to prevent recurrence of medicine errors.

Controlled drugs (medicines requiring more control because of their potential for abuse) and medicines were not always stored safely and securely. Records seen were completed in accordance with guidance. However, although there were systems in place for the safe disposal of medicines and destruction of controlled drugs staff did not always follow them. During the inspection, we saw controlled drugs such as ketamine and medicines such as adrenaline were left unattended following a paediatric emergency. This posed a safety risk as this area was not locked and there could be the potential for unauthorised people to gain access to this. Following the inspection, we received immediate assurances from the trust indicating they had quickly taken action to reduce this risk and monitor this on an ongoing basis to prevent recurrence. We escalated this to a member of staff during the inspection who took immediate action to dispose of the medicines into a sharps waste bin. However, the waste bin was full and was also in a non-secure area and was easily accessible.

Emergency medicines were available and stored in tamper evident emergency boxes. Checks were recorded and undertaken daily by staff to ensure equipment and medicines were within date and safe to use in an emergency. All the emergency boxes seen were within date and safe to use.

The service ensured that medicines were stored at the recommended room or fridge temperatures. Records seen demonstrated that medicines were stored within the recommended safe temperature range for medicines.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services. A medicine history and medicines reconciliation were undertaken and recorded on admission. This is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use. Any discrepancies or risks identified were followed up by the pharmacist and action taken.

Discharge summaries were screened by a pharmacist to ensure the correct medicines were prescribed before they were forwarded to other healthcare settings, such as the GP and community pharmacist.

Services for children and young people

Staff learned from medicine safety alerts and incidents to improve practice. The service had robust systems for reporting incidents and for receiving and dealing with medicine safety alerts. The trust's Medicine Safety Officer was involved in all medicine related incidents. For example, a staff member told us about a recent medicine safety incident where there was learning, reflection and support given to staff involved in the incident as well as further action taken to prevent the incident occurring again.

However, oxygen cylinders were not secured to the wall in line with national guidance in the resuscitation room. We raised this with senior staff during the inspection and this was resolved by the senior team immediately.

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 knew the type of incidents to report, how to escalate concerns and how to report an incident by using the trust's electronic incident reporting system. Staff and leaders reported a good culture of reporting incidents and clearly understood the importance of learning and reflecting change following incidents. For example, all trainee nursing associates gave examples of types of incidents, such as falls to report and how to escalate concerns with managers in line with the trusts escalation policy. Staff were able to explain learning shared during meetings and newsletters to mitigate any further occurrences.

Staff raised concerns and reported incidents and near misses in line with the trust policy. Staff supported to report incidents. The service reported 463 incidents from June to November 2022. Incidents reported included falls, administration errors, pressure ulcers, self-harm and staffing.

The service had no never events on any wards in children's services over the January to November 2022.

Managers shared learning with their staff about never events that happened elsewhere. The trust and children's services worked with other NHS partners to learn and support each other, with learning from incidents and particularly relating to the current areas of challenges following increased admissions. They compared incident themes and learned together how to prevent recurrences.

Incidents reported for restraint were overseen and reviewed by the vulnerabilities team to ensure learning was gained and staff used correct restraint practices in line with the trusts restraint policy.

The neonatal unit displayed a governance board within the staff area with a list of do's and don'ts. This included important notes for staff to follow from audits and information governance newsletters. Within neonates, staff encouraged parents to follow risks assessments to ensure their child remained safe on the unit.

Managers shared learning with their staff about never events that happened elsewhere. The trust and children's services worked with other NHS partners to learn and support each other, with learning from incidents and particularly relating to the current areas of challenges following increased admissions. They compared incident themes and learned together how to prevent recurrences.

Services for children and young people

Staff reported serious incidents clearly and in line with trust policy. Staff reported serious incidents within 24 hours on the trust's electronic incident reporting system. Leaders reviewed incident themes and shared these amongst the wider team, in line with their own policy and processes.

Staff understood the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in 2014. This regulation requires healthcare organisations to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or was at risk of harm. The duty of candour applies when a patient has sustained serious or moderate levels of harm.

Staff were open and transparent, and gave children, young people, and their families a full explanation if and when things went wrong. Managers investigated incidents and appropriately applied duty of candour. Leaders were open and transparent and gave an explanation when things went wrong. Children's services looked at themes in areas of change and looked for solutions to further prevent incidents.

Staff met to discuss the feedback and look at improvements to children and young people's care. Staff received feedback through handovers, communication, and wider team meetings. Staff told us senior staff acknowledged when good practices were really working, and managers took on board suggestions from the frontline staff to improve practices.

There was evidence that changes had been made as a result of feedback, during governance meetings and newsletters where improvements were made.

Managers investigated incidents thoroughly. Children, young people, and their families were involved during this process and were informed if there were delays. Senior leaders discussed incidents at governance assurance meetings including actions taken, learning to prevent recurrence and responding to families.

Managers debriefed and supported staff after any serious incident. Staff told us they were informed when things went wrong and learned from this. For example, learning from a serious incident where a child with significant mental health concerns was restrained was shared among staff. Leaders jointly worked with an external agency to improve their restraining practice for children with mental health concerns following this incident.

Is the service well-led?

Good

We rated well led 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 children and young person's division was supported by 2 deputy medical directors who worked with a positive culture of professional challenge across the senior leadership team with a high level of trust and support. A consultant obstetrician oversaw the clinical leads for the children's and young person's service who had close links with a consultant paediatrician who was the clinical lead for obstetrics and gynaecology. This ensured there was coordinated clinical oversight for the service and this promoted new initiatives.

The director of nursing led paediatrics and was supported by an operations lead, general manager, and matron. All senior leaders were clear about their responsibilities and took accountability for their area and worked collaboratively.

Leaders had oversight of the service and worked to address the challenges they currently faced within the department, low staffing levels. Leaders were aware of the divisional risks and were implementing mitigating actions in response to the increased admissions the department was currently experiencing. We saw senior leaders who were visible on all wards, staff confirmed this and expressed leaders were very supportive. All ward managers and matrons regularly worked within the clinical environment to help to fill staffing gaps within the nursing staff rotas and to ensure there was a suitable skill mix to safely care for the acuity of children and young people being cared for.

The trust encouraged development of staff to support staffing challenges. We spoke with 6 trainee nursing associates and the head of education. Leaders utilised skills of nursing associates to bridge the gaps in nurse staffing alongside ongoing recruitment within paediatrics. Trainee nursing associates understood the challenges and supported paediatric staff.

The service's senior team were flexible and covered each other so there was always senior support and advice available to staff. There was a strong essence of team working and evidence of good communication between junior doctors and senior staff to keep children safe. Staff were encouraged to develop and take on further training and were supported to do this.

Leaders encouraged newly qualified nurses to develop by asking what they were looking for as career and supporting them to gain skills and experience.

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.

The trust's vision was building healthier lives. Values were embedded across children services; staff worked with and shared the same goal in improving care provided across children services. Staff understood the trust values and were embedded across all wards. Staff were proud to work within children services

The trust values included caring, open, respectful, responsible and inclusive.

The trust had strong links with primary and community care to help children and young people to avoid unnecessary visits into the emergency department and hospital admissions.

The community team supported the service 7 days a week which helped to avoid patient admissions and facilitated safe early discharge. It was also a positive experience for children and families as they had direct access to a paediatric health

care professional if they had any concerns or worries. The team identified opportunities for expansion, such as specialist community nurses for common conditions such as epilepsy but in their absence, they supported children and families and liaised with consultant paediatricians for children with complex needs. This ensured the service was child and family focused and bridged the potential gap in primary and secondary care provision.

Following recommendations from the Neonatal Critical Care Review of December 2019 and the “Getting It Right First Time" review in 2020, senior leaders had developed plans to address the shortfall of neonatal cots over the next three years. The key objective for the trust was to increase the Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) capacity at Birmingham Heartlands Hospital to be able to manage the increased demand safely. Senior leaders aimed to achieve this by increasing the number of ITU cots at Birmingham Heartlands Hospital by 2 cots and increasing the capacity of the HDU by 2 cots. This would enable staff to cater for pre-term infants within the local population.

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.

All staff reported a positive culture across all wards and departments and shared the same goals. Staff commented on the supportive leadership team across children services. The staff described a strong teamwork across all professional groups and support staff. This extended to colleagues working in the community, such as the Paediatric Ambulatory Treatment and Care Team and those in other roles across the hospital, such as the critical care outreach team. We observed an open and inclusive culture during the inspection with positive interaction between leaders and local staff teams.

Senior leaders knew staff as individuals and operated an open-door policy and safe space to discuss any concerns. Leaders recognised the importance of supporting individuals’ wellbeing. Most staff reported they were listened to by managers across wards. However, the low staffing levels were significantly impacting on the morale and wellbeing of some nursing staff.

We saw a diverse workforce to meet the needs of the local population across children services. Leaders supported staff by recognising excellent practices within children services. Staff were passionate and showed resilience to meet the needs of children and young people despite the challenges they were facing.

Nursing staff spoke very positively about working at Birmingham Heartlands Hospital. We saw staff were very committed and dedicated to the unit and staff told us this was the best unit they had worked in. We observed staff across all wards being very caring, dedicated and professional even with the increasing number of children they were seeing and the current issues they faced with nurse staffing. Staff recognised the trust was doing everything they could to support them with the challenges they faced.

The culture from the senior team was positively embedded across children and young person’s services which encouraged the best care for children. Parents and children informed us they were able to raise concerns with nursing staff and were aware of the trust’s Patient Advice Liaison Service. Parents told us the nursing staff were very helpful and were always around to wave and smile when they walked past, despite the challenges with staffing levels.

The culture promoted openness and honesty at all levels of the organisation. This included in response to incidents with children and young people who use the services.

Services for children and young people

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 seniors' leaders were clear about their responsibilities and took accountability of their area and worked collaboratively.

Senior staff monitored monthly performance through a performance dashboard and included divisional meetings which were held monthly and jointly with nursing staff, medical staff and trust operations. This enabled emerging themes and concerns to be identified through monitoring of the quality indicators for the service and the division.

Risks, incidents, complaints, infections and positive feedback were monitored at these meetings alongside progress with required actions. The divisional leaders-built relationships and shared initiatives with other local partnering NHS hospitals. They also reviewed external reviews such as by the Care Quality Commission and feedback from patient experiences dashboards.

The children's division monitored themes to action and encourage improvement and address challenges for the service. We saw minutes from paediatric speciality management meetings held in October 2022. This included ongoing recruitment of consultants, incidents reviews and themes within paediatrics which had been identified including staff not following treatment plans. Leaders implemented an action plan and monitored required actions to minimise risk to children.

Senior leaders circulated governance newsletters every week to promote staff learning and to change practice in response to incidents in their service to prevent recurrence. For example, a memorandum was placed in staff areas and included on staff forums to be visible to staff. Staff were informed of incident trends and themes and new initiatives to strengthen the children's services.

All staff were aware of the overarching risk register across the paediatric and neonatal unit. This was included in a governance newsletter in November 2022.

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.

Service leaders used their systems and processes to manage performance effectively. This included conducting clinical quality audits, reviewing themes of incidents and monitoring children's services performance on an overall risk register. Progress against required actions were monitored through a performance dashboard and improvements needed were fed back to the local teams to address.

Senior staff monitored the local risk register for paediatrics and neonates. This included the risk of medication errors due to a lack of adequate funded pharmacy, environment, the number of admissions and nurse staffing levels. The trust worked to reduce risk and looked for ways to minimise risk such as bridging gaps in staffing levels by active recruitment. This was discussed at governance meetings.

Services for children and young people

The children services had a paediatric and neonatal risk register to monitor the progress against required actions and to mitigate risks. Senior leaders had oversight of the divisional risk register which reflected the main concerns which staff told us about. For example, the service's main risks were an increase in admissions, lack of capacity in the department including limited numbers of cots within the neonatal unit, overall environment, staffing levels, increased admissions of children with mental health concerns and the provision of respiratory care. Service leaders reviewed progress against actions required to mitigate risks to meet the needs of the local population and the challenges with an increase in flow and activity in the service.

The number of children and young people admitted was increasing due to a lack of mental health provision across the local system. We saw multi-disciplinary meeting minutes which recorded discussions regarding a child awaiting a tier 4 bed within the community. Staff took action to mitigate risk and assessed triggers which were supported by the safeguarding lead.

The trust had identified risks for children on a mental health pathway when they were admitted to hospital. The trust updated their restraint policy in June 2022 in response to identified risks following an incident in the service. An overall risk assessment was used to keep children safe. Staff understood working in line with policies for children with a mental health condition and recently had learned for child with complex mental health concerns. The staff openly shared learning with inspectors.

Senior leaders regularly reviewed staffing levels and where staffing levels were below planned levels staff were redeployed from other wards and senior staff and matrons supported clinically when required. Children services was experiencing an increase in the number of children being admitted with complex conditions. Senior leaders monitored staffing levels regularly staffing levels daily to ensure there were enough competent staff to support the number of children with respiratory and complexity of cases admitted within children services.

Leaders planned for challenges and adverse events for the winter months due to an expected increase in admissions. They worked together with community services and other partnering hospitals.

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.

Divisional meetings used data to inform discussions around staffing and incident trends, audit findings and overall audit performance.

Managers reviewed information about the service to ensure they understood the quality of care provided.

Leaders monitored a live tracker to identify delays in transferring children living with mental health concerns to a mental health community bed. In addition, the tracker identified where children had long stays whilst awaiting a community bed.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Services for children and young people

Staff engaged with parents and children including at local schools. Staff attended a young person's council with social visits on Saturdays where they talked to children. The children services worked with a health education and youth social action initiative. They held a number of events with 7 schools, 160 pupils from years 6-10 to promote how to choose services wisely such as GPs, the emergency department and self-help services.

The trust encouraged patient feedback. This included from a national survey which was targeted at age groups of 0 to 15-year olds. Some areas did not meet the national average for the survey and achieved 16%. The service made significant improvements in response. Feedback from the survey included positive comments of staff kindness and professionalism from patients and families. The trust monitored patient experience dashboards and fed back locally. The service also had age specific feedback books for children and their families to feed back about their experiences of the service. The chief nurse led the patient experience group each month and was represented from all divisions.

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 children services had systems to support improvement and innovation work to drive positive change in the areas providing care for children.

The trust worked in partnership with a special needs school to develop children's health and wellbeing passports. This ensured they were easy to read particularly for children living with a learning disability and to enhance the patient experience across all areas where children were cared for.

The paediatric team received "The Best Training Unit "award at the West Midlands Paediatric Awards for Training Achievements in 2022.

The trust led an innovative recruitment campaign for the paediatric and neonatal services and produced a showcase video in 2022 to build recruitment and retention across all children services. This was shared through social media and job adverts.

Leaders encouraged innovative ways of working.

Staff were proud to achieve an award at the British Association of Perinatal Medicine Gopi Menon Awards, 2022 for the Neonatal team. This award was for the Neonatal Community Outreach Team for delivering phototherapy to babies at home. They also achieved a bronze award in the Bliss Baby Charter Programme in September 2022. Staff shared their achievements during the inspection and told us they looked for ways to provide the best patient care.

Children's services worked within the current British Association of Perinatal Medicine Standards of Family Integrated Care which included:

- Partnership with families
- Empowerment
- Wellbeing

- Culture
- Environment

The trust had a family integrated care lead nurse who was responsible for leading change in practice across the neonatal unit by meeting with parents, supporting and encouraging them to be present and involved with their baby as much as possible whilst they were on the Neonatal Unit. Staff provided them with functional skills required to care for their baby on the Neonatal Unit; this included training parents to feed their baby via nasogastric tube, both on the Neonatal Unit and when their baby was ready to be discharged home.

The trust was planning a quality improvement project to ensure all parents were given the required information within 72 hours of admission to the neonatal unit. This included providing skin-to-skin contact as soon as possible.

Areas for improvement

MUSTS

Action the trust MUST take to improve:

- The trust must ensure there are enough nursing staff on the wards and in the community to safely care for patients. (Regulation 18 (1) Staffing)
- The trust must ensure staff safely store and dispose of medicines and controlled drugs within the high dependency unit. (Regulation 12 (2) (g) Safe care and treatment)

SHOULDS

Action the trust SHOULD take to improve:

- The trust should ensure equipment is checked and locked way if it is not fit for use. (Regulation 15 (1)(e), Premises and equipment)
- The trust should ensure staff always wear personal protective equipment in line with trust policies and guidance to prevent infections within clinical areas. (Regulation 12 (h), Safe care and treatment)
- The trust should ensure children and their families always have easy access to working call bells. (Regulation 15 (1)(c), Premises and equipment)
- The trust should ensure they monitor records within the housekeeping department to ensure cleaning records are kept up-to-date, particularly on ward 15. (Regulation 15, 1 (a) Premises and equipment)

Our inspection team

Medical Assessment Unit

How we carried out the inspection

We carried out an unannounced focused inspection, looking at two key questions: Is the service safe and well led.

The medicine core service inspection was carried out by 1 inspector and 1 specialist advisor with a nursing background in medicine. An inspection manager oversaw 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.

During the inspection we spoke with 11 staff including matrons, consultants, junior doctors, nurses, pharmacists, and housekeepers.

During the inspection we reviewed 18 sets of patient records and spoke with 4 patients/family members. These included risk assessments where required, National Early Warning Score 2, falls risk assessments and any pain relief that had been administered.

Children and Young Persons:

How we carried out the inspection

Children and Young Persons: Overall Service Rating: unrated

We carried out an unannounced focused inspection, looking at two key questions: Is the service safe, and well led.

We spoke with approximately 24 staff, reviewed 16 records and spoke to 14 children and their parents from toddlers to 15-year-olds. We reviewed results from patient voices.

We conducted 3 interviews of senior leaders following the inspection.

The team that inspected the children and young person's service comprised a CQC (Care Quality Commission) lead inspector, a CQC inspector, a children's specialist inspector, a CQC specialist pharmacist and a specialist adviser with extensive experience in children and young person's services. The inspection team was overseen by an inspection manager.

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.