

# Great Ormond Street Hospital for Children NHS Foundation Trust

## Inspection report

Great Ormond Street Hospital  
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Date of inspection visit: 01 October to 7 November 2019  
Date of publication: 22/01/2020

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.






This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall trust quality rating

Good 

Are services safe?	Requires improvement 
Are services effective?	Outstanding 
Are services caring?	Outstanding 
Are services responsive?	Good 
Are services well-led?	Good 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

# Summary of findings

## Background to the trust

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) was established in 1852 in the London Borough of Camden and was the first hospital providing in-patient beds specifically for children in England. Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust achieved foundation trust status on 01 March 2012.

The hospital is the only specialist children's hospital in the UK that does not have an accident and emergency department. All children treated at the hospital are referred from other hospitals or their general practitioner, both within and outside the UK.

The trust operates from a single site in central London and has approximately 418 beds. It is registered with the Care Quality Commission (CQC) to care for children aged 0 to 18 year of age. Together with the UCL Institute of Child Health, it forms the UK's only academic biomedical research centre specialising in paediatrics.

The trust was last inspected in January 2018 (report published April 2018). The trust rating stayed the same since our last inspection, we rated the trust overall as good.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as Good** ● → ←

## What this trust does

Great Ormond Street Hospital for Children NHS Foundation Trust is a tertiary specialist children's hospital and has the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. Children are also treated from overseas in the International and Private Patients' (IPP) department.

There are more than 50 different clinical specialties at Great Ormond Street Hospital (GOSH). It provides surgery, medical care, critical care, end of life care, outpatients services, and child and adolescent mental health services. The hospital has 418 beds including there are 42 critical care beds, seven inpatient mental health beds and three-day case mental health beds.

The tier 4 child and adolescent mental health inpatient unit (Mildred Creak unit) provides care to young people aged seven to 14 years for a range of complex social and emotional mental health needs. The trust does not admit patients held under the Mental Health Act. The unit works in collaboration with the local community mental health trust so that if required, the Mental Health Act can be applied on site, before the child is transferred to an appropriate alternative location.

Between March 2018 to February 2019, the trust had 40,349 elective admissions of which 26,583 were day cases and 13,766 were elective and 3,038 non-elective admissions. On a weekly basis on average 4,673 patients were seen in the outpatient's department.

The trust provides surgical treatment for rare and complex conditions. It is the only centre nationally that provides tongue reduction surgery for macroglossia associated with Beckwith Wiedemann Syndrome. Data demonstrates a decreasing surgical complications and excellent functional outcomes for these children.

# Summary of findings

The trust is the world leading centre for children requiring slide tracheoplasties and has the largest series of slide tracheoplasties to treat long segment tracheal stenosis. Data shows a significant improvement in survival over time, despite increasing patient complexity.

In 2018 GOSH collaborated with University College London Hospital and researchers from University College London to carry out the first two operations on the damaged spinal cords of babies in the womb in the UK.

In 2019 GOSH was officially recognised as a Centre of Clinical Excellence by Muscular Dystrophy UK. The hospital provides comprehensive services for children and young people with muscle wasting conditions and provides the highest number of dedicated neuromuscular clinics nationally.

The trust is the largest centre in the UK for children with heart or brain problems, and the largest children's cancer centre in Europe. In 2018 GOSH became the first hospital in the UK to offer a new pioneering cancer treatment to children. Patients with B-Cell acute lymphoblastic leukaemia (ALL) can now receive the new personalised treatment, known as CAR-T therapy. This is the first treatment of its kind to become available to UK patient's outside of clinical trials.

The neurosurgical team at GOSH is providing the first Laser Interstitial Thermal Therapy (LITT). This is a minimally invasive treatment which is designed to destroy abnormal brain tissue in an extremely targeted manner, whilst causing minimal damage to overlying or surrounding health brain tissue. It is particularly helpful in treatment of epilepsy-causing or malignant lesions in deep and difficult to access areas of the brain. It reduces the high risk of complications including endocrine disturbance, stroke, visual loss and memory disturbance.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. Our planning decisions took account of information provided by the trust, and information we had collected and reviewed during the past year. This included feedback from patients, the public, staff and other stakeholders.

We carried out the unannounced core service inspection on 01-03 October 2019. We inspected the core services of critical care, surgery and child and adolescent mental health services at Great Ormond Street Hospital (GOSH).

We also inspected the well-led key question for the trust overall. We summarise what we found in the section headed Is this organisation well-led? The announced well-led part of the inspection took place on 06-07 November 2019.

We held discussions with staff prior to inspection and attended the young people's forum and a trust board meeting.

During inspection we spoke to staff from a range of clinical areas and disciplines and at different grades. This included: healthcare assistants; housekeeping, nurses, doctors, consultants, and allied health professionals. We spoke with members of the leadership team, which included executives, non-executive directors, the chair and company secretary.

# Summary of findings

We reviewed patient related information, including many electronic patient records and risk assessment tools. We looked at policies and procedures, safety checks and medicines records. In addition, we reviewed minutes of meetings, formal performance reports, risk registers and other governance information.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- Overall, we rated effective and caring as outstanding, responsive and well led as good, and safe as requires improvement. We rated two of the trust's eight services as outstanding and six as good. In rating the trust, we considered the current ratings of the five services not inspected this time.

Our full Inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website.

We rated well-led for the trust overall as good.

### Are services safe?

Our rating of safe went down. We rated it as requires improvement because:

- Some services did not always control infection risk well. Staff used equipment and control measures inconsistently, they did not always use hand sanitisers when entering or leaving the wards, or when moving between patient bays
- In some clinical areas, systems to ensure equipment was maintained and safe to use were not effective and did not always follow national guidance.
- The service did not always use systems and processes to safely store, record or destroy medicines in line with legislation.
- Pharmacy provision on the critical care wards was below that recommended by the Society of Critical Care Medicine.

However

- The service provided mandatory training in key skills in line with trust targets.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- 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 nurse staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff knew how to assess, monitor and manage patient risk. Staff identified and quickly acted upon children and young people at risk of deterioration.
- 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.

# Summary of findings

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learnt with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results to improve safety. Staff collected safety information and shared it with staff, children, young people and parents.

## Are services effective?

Our rating of effective stayed the same. We rated it as outstanding because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored children and young people regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools. Children and young people were given pain relief in a timely way.
- Staff actively monitored the effectiveness of care and treatment. Opportunities to participate in benchmarking, peer review and research were proactively pursued. They used the findings to make improvements and achieved good outcomes for patients.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide high quality, effective care.
- Key services were available 24 hours a day, seven days a week to support timely patient care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support those children, young people and or their families who lacked capacity to make their own decisions or were experiencing mental ill health.

## Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- Staff treated all children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff took time to interact with children, young people and their families in a respectful and considerate way.

# Summary of findings

- Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. There was access to a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment.
- Staff understood the emotional and social impact that a patient's care, treatment or condition had on their wellbeing and the whole family.
- Staff supported and involved children, young people, families and carers to understand their condition and make decisions about their care and treatment. They communicated with the child about their care and treatment in a way they could understand, using toys or books to help explain.
- Children and their families were consistently positive about how staff treated them. They told us that staff went the extra mile and that the care their child received exceeded their expectations.
- Staff provided children, young people and their families with relevant information, both verbal and written, so they could make informed decisions about their care and treatment.
- Children and young people and parents were treated as important partners in the delivery of care.
- The palliative care team worked collaboratively with the clinical staff and family liaison team to manage end of life patients and ensure parents received the support and guidance that met their individual needs.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of children, young people and their families served. They pro-actively liaised with services and with others in the wider system and local/national organisations to manage the discharge care pathway and plan future care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Children and young people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge were mostly in line with national standards.
- Children, young people and their families could easily give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with all staff. The service included children and their families in the investigation of their complaint.

## Are services well-led?

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

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

# Summary of findings

- Most services had a vision and strategy for what they wanted to achieve, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and were aligned to trust's plans and developments within paediatrics.
- The culture of the services provided were centred on the needs and experiences of children, young people and their families who used services. The service had an open culture where children, young people, their families and staff could raise concerns without fear.
- Staff felt respected, supported and valued. The services promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders operated effective governance processes, throughout the service. However, the planning and implementation of the electronic patient record did not meet the individual needs of all services. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- There was a culture of collective responsibility between teams and services and positive relationships between staff and teams.
- Data or notifications were consistently submitted to external organisations as required.
- The service had plans to cope with unexpected events and staff were aware of actions they needed to take to achieve safe continuity of services.
- Leaders and staff actively and openly engaged with children, young people and their families, staff, equality groups, the public and local and national organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- 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.

However;

- Although staff could access the data they needed, in easily accessible formats, to understand performance, make decisions and improvements, this data was not always accurate or reliable. Work was in progress to integrate information systems.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice at Great Ormond Street Hospital at trust wide level and in surgery and critical.

For more information, see the Outstanding practice section of this report.

# Summary of findings

## Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found 19 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

## Action we have taken

We issued two requirement notices to the trust. Our action related to breaches of one legal requirement at a trust-wide level and two were in the core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

### Trust well led

- The trust's young people's forum actively engaged with young people and their siblings to ensure their views and experiences influenced and informed service developments in the trust.
- The neuromuscular study of children living with spinal muscular atrophy lead by the trust resulted in a drug being licenced and approved by NICE. This will improve their quality of life and delay progression of the disease.
- The trust's Gene therapy programme, a new type of therapy where a working copy of the gene can be inserted into the patients' own cells using a modified, harmless virus, has resulted in patients with severe combined immunodeficiency being cured without a transplant.
- A GOSH consultant neurologist coordinated the EpiCARE European Reference Network for Rare and Complex Epilepsies. The network was recently awarded a Silver Dolphin Award at the 10th Cannes Corporate Media & TV Awards for a short film which demonstrated a Europe-wide collaboration that helped a four-year-old Finnish boy diagnosed with hypothalamic hamartoma. This support and advice improved the boy's quality of life.
- The trust had held two 'Play street' events in July and October 2019, as part of the local clean air campaign, which the local council was very supportive of. The road outside the hospital was closed to traffic and games and activities were provided. This event not only promoted clean air and the benefits to children but provided an opportunity to engage with the local schools who attended.
- The teen careers fair for the trust's patients, introduced these young people to a range of companies, assisted them to sign up to work experience opportunities while learning new skills and take part in workshops. The day was positively evaluated and demonstrated to young people what they could achieve despite having a health condition.
- There was a structured appraisal process for the NEDs, that included a view of their attendance and contribution at specific groups and committees. This along with feedback from the council of governors informed their appraisal which was co-ordinated by the company secretary.



# Summary of findings

## Critical care

- The senior leadership team had introduced weekly psychological support sessions. These weekly sessions were supported by the ad hoc provision that was available when staff were aware of a possible bereavement. This approach ensured emotional support was provided at a “pre-brief”, which also allowed staff to be proactively supported and arrange a commemoration service for patients if they wished.
- Family liaison sisters provided support to families during a bereavement or to those families needing additional support. In the event of an expected bereavement, the family liaison team worked proactively in collaboration with the palliative care team to provide additional support, and access to psychology support for families and siblings. This facilitated individual timely support at the level the family and siblings required.
- The critical care research team were embedded in the critical care areas working in collaboration with clinical and academic teams. They were involved in numerous local, national, and international clinical and academic research projects that had resulted in improvements to patient treatment and outcomes.
- Critical care staff were lead authors on four of the eight multiple centre trials published globally in paediatric intensive care in 2018 and 2019. They were the largest global contributor from any the paediatric intensive care units.

## Surgery

- To support complex cardiac surgery the service had recently started using pioneering 3D heart modelling and virtual reality. A virtual reality model of a patient’s heart can assist clinicians to virtually plan and practice complex procedures ahead of surgery, contributing to improved patient outcomes.
- In collaboration with a local acute NHS trust and local university, the service successfully performed specialist fetal surgery, the first surgery of its kind in the UK. In comparison to postnatal surgery, fetal surgery has been shown to improve short and medium-term outcomes, preventing damage to the baby’s spinal cord in the last trimester of pregnancy.
- To improve the child and their families experience several initiatives across the service had been introduced. For example, a poet visited the surgical wards and created bespoke poems for patients to reduce their anxiety. The trust had also recently employed its first full-time music therapist, providing patients with opportunities for creative expression.
- The service participated in the Harvey’s gang initiative, allowing children with complex needs and long-term conditions to become trainee biomedical scientists for the day. This helped children gain a better understanding of what happens to their blood samples.

# Summary of findings

- The trust had a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment. Play staff held blood parties using disco lights and sensory equipment to distract patients while the child was having their blood taken.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations.

We told the trust that it must take action to bring services into line with three legal requirements.

### **Trust well led**

The trust **MUST**:

- Ensure the board assurance framework reflects all known medicine risks, including the storing, administration and destroying of medicines in line with legislation and the trust medicines management policies.

### **Critical care**

The trust **MUST**:

- Ensure medicines are stored safely, in line with legislation and the trust medicines management policies.

### **Surgery**

The trust **MUST**:

- Ensure medicines are stored safely and destroyed in line with legislation and the trust medicines management policies.

### **Child and Adolescent Mental Health services**

The trust **MUST**:

- Ensure that the electronic patient record system meets the needs of the service, so staff can record, update and find patient records promptly. This includes further development of, and staff adherence to, electronic patient record storage protocols.

Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

# Summary of findings

## Trust wide

The trust SHOULD;

- Continue to develop and implement a formal board development programme.
- Take action to develop and assure itself about financial sustainability going forward.
- Continue to promote the role of the FTSUG, taking proactive action to identify and address themes from staff contacts with the FTSUG.
- Raise staff awareness of the safe and respectful behaviour policy and improve access to conflict resolution training.
- Continue to improve the quality of WRES data to enable this to be used to inform areas for development.
- Raise staff awareness of the role of the accredited safety champions.
- Clarify the role and expectations of governors in interview stakeholder groups, including for which roles they will be invited to participate in groups for.
- Improve the oversight of delivery of services by the pharmacy department, including identifying and reporting key performance indicators via the directorate performance process to the board.
- Take action to improve the number of incidents closed within the trust's 45 working day target.
- Improve the accuracy of the trust's information asset register.

## Critical care

The trust SHOULD;

- Consider developing a directorate clinical strategy for critical care areas.
- Provide consistent checks in relation to all in use resuscitation equipment in the critical care areas, in line with guidance from the Resuscitation Council.

## Surgery

The trust SHOULD;

- Improve the timeliness of discharge summaries sent to the patient's GP.
- Continue work to improve referral to treatment times.
- Review and improve systems for equipment maintenance in theatres so that staff are assured it is fit for use.

## Child and Adolescent Mental Health services

The trust SHOULD;

- Continue to take action so that staff, patients, family members and carers are not negatively affected by the lack of disabled access to the roof terrace.
- Provide training and support to all relevant staff so that they are competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years.

# Summary of findings

- Provide timely administrative support for the service, so audits and document scanning are not delayed.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services, in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust improved. We rated well-led as good because:

- Managers at all levels in the trust had the skills, knowledge and experience to run a service providing high-quality sustainable care. Leadership had been strengthened since the last inspection with several changes of both executives and non-executives. The executives were described as an inclusive, dynamic team who were open and transparent.
- Leaders were knowledgeable about the challenges to quality and sustainability the trust faced including those arising from the current NHS financing model for specialised services; and its dependence on continuing to be able to attract international private patients. Leaders were proactive in addressing these through a range of initiatives including exploring alternative international markets and research activity.
- The trust had a vision and strategy, that was currently being refreshed in consultation with staff, children, families and stakeholders. Staff understood the trust's vision, values and strategy and were supportive of these. Several strategies to support the trust strategy were either in place or currently being developed. These aligned and supported the trust's vision.
- The hospital had a culture in which staff could speak openly about safety concerns allowing these to be effectively managed and safe high-quality care delivered. Leaders at all levels across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Leaders did not tolerate behaviour that was not in line with the trust's values, regardless of seniority. In some directorates staff continued to report issues with bullying and harassment, low morale and lack of staff engagement. Several initiatives had been implemented to address these including a 'stand up for our values', program to tackle those behaviours that were not in line with the trust's values and promoting the Dignity at work policy. At the time of our inspection the impact of these initiatives had not yet been measured but will be measured through the next NHS staff survey and staff engagement.
- Staff, patients and relatives were actively encouraged to raise concerns and the systems and processes in place made this accessible to all. The trust did not tolerate violence and aggression towards its staff and had a range of initiatives in place to address this.
- All staff were provided with the opportunity to participate in appraisal. Many areas had succession planning in place for leadership roles and staff were provided with opportunities to develop the skills and knowledge to be successful in obtaining promotion.
- Staff considered that quality was always given the same priority as finances. The focus was always on safety and quality when decisions about service developments and financial restraints were being discussed. They felt confident that quality was not being compromised to manage financial balance and the medical director and chief nurse took the lead in ensuring all cost improvement programmes did not negatively impact on quality.

# Summary of findings

- Since the last inspection the trust had reviewed its governance structure in consultation with staff looking at what was currently working well and what needed improvement. The trust had a strategic plan, operational plans and supporting strategies that clearly articulated the trust's objectives, requirements and performance standards.
- There were clear reporting lines from ward to board and from board to wards, to manage performance and identify potential issues or failure to meet local and national standards. These were informed by the integrated quality and performance report which included both safety and financial information and discussed at the monthly directorate performance review meetings, attended by the directorate management team and representatives from the trust executives.
- The trust had developed a long-term financial model that was subject to regular in-depth scrutiny by the board through its finance and investment committee. The trust had concluded that, under current NHS financial assumptions, it was likely to face significant financial challenge over the next two years.
- Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives.
- The board were sighted on information governance issues including some issues with data quality which could impact on its ability to accurately report performance internal and externally. While data quality was improving, and action was taken when specific data issues were identified, more work was required to ensure accurate data was available to inform discussions and provide assurance.
- There was a clear system for categorising, reporting, investigating and learning from serious incidents, supported by the incident reporting and learning policy and duty of candour policy. Themes from serious incidents were used to inform targeted improvement work or organisational learning, for example the changes to handover and provision of revised duty of candour training.
- Children, young people and their families were aware of how to raise a complaint. Complaints and concerns were taken seriously and responded to in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns being raised.
- The trust had systems and processes for identifying risks, planning to eliminate or reduce these, and coping with both the expected and unexpected. The risks recorded on the corporate risks register reflected those that leaders stated were the top risks and there was evidence that these were regularly reviewed.
- The trust had taken a range of approaches to actively engage with patients, staff and stakeholders to plan, develop and manage services and collaborated with partner organisations effectively. There was evidence the trust had changed its attitude and approach to stakeholder working with an increased emphasis on commitment to partnership working with others.
- The trust was leading and participating in numerous research projects and had systems and processes in place to achieve its aim of being a research hospital. Staff at all levels were encouraged and supported to participate and lead research projects, many of which had resulted in improvements in treatments and patient outcomes.
- The trust were committed to learning and continually improving services from internal and external reviews. There were systems and processes in place to manage quality improvement projects including an agreed trust wide improvement methodology.
- The hospital participated in networks with other trusts in the UK and internationally to improve children's health. Some of these networks were chaired by trust clinicians, while others the trust had representation on. We saw examples where the work of these networks had resulted in positive impacts for children and their families.

# Summary of findings

However;

- The trust acknowledged that their WRES performance was poor and this was an area that had not been focused on for the last three years. They considered they were behind other trusts but had plans to address this. Action was being taken and the results had been used to draft an action plan .

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Jan 2020	Outstanding ↔ Jan 2020	Outstanding ↔ Jan 2020	Good ↔ Jan 2020	Good ↑ Jan 2020	Good ↔ Jan 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Ratings for Great Ormond Street Hospital NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016
Surgery	Requires improvement ↔ Jan 2020	Outstanding ↑ Jan 2020	Outstanding ↑ Jan 2020	Good ↔ Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Critical care	Requires improvement ↓ Jan 2020	Good ↔ Jan 2020	Outstanding ↔ Jan 2020	Good ↔ Jan 2020	Good ↑ Jan 2020	Good ↔ Jan 2020
Neonatal services	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Transition services	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Requires improvement Jan 2016	Good Jan 2016
End of life care	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016
Outpatients	Good Apr 2018	N/A	Outstanding Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Child and adolescent mental health wards	Good ↔ Jan 2020	Good ↔ Jan 2020	Good ↓ Jan 2020	Good ↔ Jan 2020	Requires improvement ↓ Jan 2020	Good ↔ Jan 2020

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.



# Acute health services

## Background to acute health services

Great Ormond Street Hospital for Children NHS Foundation Trust is a tertiary specialist children's hospital and has the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. Children are also treated from overseas in the International and Private Patients' (IPP) wing.

There are more than 50 different clinical specialties at Great Ormond Street Hospital (GOSH). It provides surgery, medical care, critical care, end of life care, outpatients services, and child and adolescent mental health services. The hospital has 418 beds including there are 42 critical care beds, seven inpatient mental health beds and three-day case mental health beds.

Between March 2018 to February 2019, the trust had 40,349 elective admissions of which 26,583 were day cases and 13,766 were elective and 3,038 non-elective admissions. On a weekly basis on average 4,673 patients were seen in the outpatient's department.

We carried out the unannounced core service inspection on 01-03 October 2019. We inspected the core services of critical care, surgery and child and adolescent mental health services at Great Ormond Street Hospital (GOSH). During our inspection we spoke with 31 children and young people, 150 staff, 18 carers/relatives.

We observed care and looked at a wide range of documents including patient records, policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of acute services

**Good**   

Our rating of services stayed the same. We rated it them as good because:

- The service provided mandatory training in key skills in line with trust targets.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff knew how to assess, monitor and manage patient risk. Staff identified and quickly acted upon children and young people at risk of deterioration.
- 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.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

# Summary of findings

- Staff assessed and monitored children and young people regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools. Children and young people were given pain relief in a timely way.
- Staff actively monitored the effectiveness of care and treatment. Opportunities to participate in benchmarking, peer review and research were proactively pursued. They used the findings to make improvements and achieved good outcomes for patients.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide high quality, effective care.
- Staff treated all children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff took time to interact with children, young people and their families in a respectful and considerate way.
- Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. There was access to a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment.
- Children and young people and parents were treated as important partners in the delivery of care.
- The service planned and provided care in a way that met the needs of children, young people and their families served. They pro-actively liaised with services and with others in the wider system and local/national organisations to manage the discharge care pathway and plan future care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The culture of the services provided were centred on the needs and experiences of children, young people and their families who used services. The service had an open culture where children, young people, their families and staff could raise concerns without fear.
- Staff felt respected, supported and valued. The services promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders operated effective governance processes, throughout the service. However, the planning and implementation of the electronic patient record did not meet the individual needs of all services. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with children, young people and their families, staff, equality groups, the public and local and national organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However;

- The service did not always use systems and processes to safely store, record or destroy medicines in line with legislation.

# Great Ormond Street Hospital

Great Ormond Street  
London  
WC1N 3JH  
Tel: 02074059200  
[www.gosh.nhs.uk](http://www.gosh.nhs.uk)

## Key facts and figures

Great Ormond Street Hospital for Children NHS Foundation Trust is a tertiary specialist children's hospital and has the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. Children are also treated from overseas in the International and Private Patients' (IPP) wing.

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We observed care and looked at a wide range of documents including patient records, policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of services at Great Ormond Street Hospital

**Good**   

Our rating of services stayed the same. We rated it them as good because:

- The service provided mandatory training in key skills in line with trust targets.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff knew how to assess, monitor and manage patient risk. Staff identified and quickly acted upon children and young people at risk of deterioration.

# Summary of findings

- 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.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored children and young people regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools. Children and young people were given pain relief in a timely way.
- Staff actively monitored the effectiveness of care and treatment. Opportunities to participate in benchmarking, peer review and research were proactively pursued. They used the findings to make improvements and achieved good outcomes for patients.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide high quality, effective care.
- Staff treated all children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff took time to interact with children, young people and their families in a respectful and considerate way.
- Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. There was access to a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment.
- Children and young people and parents were treated as important partners in the delivery of care.
- The service planned and provided care in a way that met the needs of children, young people and their families served. They pro-actively liaised with services and with others in the wider system and local/national organisations to manage the discharge care pathway and plan future care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The culture of the services provided were centred on the needs and experiences of children, young people and their families who used services. The service had an open culture where children, young people, their families and staff could raise concerns without fear.
- Staff felt respected, supported and valued. The services promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders operated effective governance processes, throughout the service. However, the planning and implementation of the electronic patient record did not meet the individual needs of all services. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with children, young people and their families, staff, equality groups, the public and local and national organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However;

# Summary of findings

- The service did not always use systems and processes to safely store, record or destroy medicines in line with legislation.

# Surgery

Good  

## Key facts and figures

Great Ormond Street Hospital for Children NHS Foundation Trust provides elective and emergency surgical services to children and young people. As a tertiary hospital, patients are referred from other healthcare providers throughout the UK and overseas.

Surgery services include: general surgery; orthopaedics; cardiac surgery; urology; transplant; neurosurgery; ear, nose and throat (ENT); and plastics.

From March 2018 to February 2019, the trust had 7,330-daycase admissions, 297 emergency admissions and 5,196 elective admissions.

*(Source: Hospital Episode Statistics)*

Surgery services at Great Ormond Street Hospital are provided within six of the eight directorates.

There were ten surgical in-patient wards, of which five wards are equipped to provide care for patients who need high dependency care. There was a designated day care ward and a pre-assessment unit. The hospital has 14 operating theatres and two recovery areas, one with an infectious patient bay. A 24-hour, seven day a week emergency theatre and anaesthetic room is available.

During this inspection, we visited 10 surgical wards, the main theatres and the interventional radiology theatres over three days during our unannounced inspection on 1 October to 3 October 2019.

We spoke with 26 children and young people and 10 parents, and 106 members of staff including medical and nursing staff, healthcare assistants, therapy and domestic staff. We observed care and looked at a wide range of documents including patient records, policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. Staff kept detailed, up to date records of children and young people's care and treatment. The service-controlled infection risk well. Staff knew how to assess, monitor and manage patient risk. The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and research were proactively pursued. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff worked well together for the benefit of patients. Staff advised patients on how to lead healthier lives and supported them to make decisions about their care. Key services were available seven days a week.

# Surgery

- Staff respected patient's privacy and dignity. They provided emotional support to patients, families and carers and helped them understand their conditions. Patient and parent feedback was consistently positive. Children and young people told us staff treated them well and with kindness. Parents told us that staff went the extra mile and that the care their child received exceeded expectations.
- The service planned and delivered care, in collaboration with other organisations, to meet the needs of patients. Staff took account of children, young people and their parents' individual needs and preferences. The trust made it easy for children, young people and parents to give feedback and used this information to improve care and services provided.
- Leaders had the skills and knowledge to deliver effective services. They supported and encouraged 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 and were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- In theatres, systems to ensure equipment was maintained and safe to use were not effective.
- Not all medicines were stored safely or destroyed in line with legislation.
- Discharge summaries and clinic letters were not always sent to the patient's GP in a timely manner.
- Staff were unclear whether information leaflets were available in different languages and formats.
- The service was looking at ways to improve access, as referral to treatment times were below the England average.

## Is the service safe?

**Requires improvement** ● → ←

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

- In theatres, systems to ensure equipment was maintained and safe to use were not effective.
- Discharge summaries and clinic letters were not always sent to the patient's GP in a timely manner.
- Not all medicines were stored safely or destroyed in line with legislation.
- Treatment rooms where medicines were stored were secured using swipe cards. On the wards without electronic cabinets to store medicines, we saw that medicines cupboards and fridges within the room were unlocked. We were told that access was controlled by the ward matron and the pharmacy department who authorised this access, in line with trust policy. However, we observed non-clinical staff also had access to the treatment room, and therefore the medicines.

However:

- The service provided mandatory training in key skills and ensured that all staff had completed this training.
- The service had effective processes in place to keep people safe and protected from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, their families and themselves from infection. They kept equipment and the premises visibly clean.
- In most areas the design, maintenance and use of facilities, premises and equipment kept people safe.

# Surgery

- Staff knew how to assess, monitor and manage patient risk. Staff identified and quickly acted upon children and young people at risk of deterioration.
- Despite vacancies, nursing staffing levels and skill mix were planned and reviewed to keep patients safe. Managers gave bank and agency staff a full induction.
- The service had enough staff with the right skills, training and experience to keep patients safe.
- Staff kept detailed, up to date records of children and young people's care and treatment. Records were stored securely and easily available to all staff providing care.
- Staff safely prescribed, administered and recorded medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learnt with staff. When things went wrong, staff apologised and gave children, young people and their families honest information and support.
- The service used monitoring results to improve safety. Staff collected safety information and shared it with staff, children, young people and their families.

## Is the service effective?

**Outstanding**  

Our rating of effective improved. We rated it as outstanding because:

- The service provided care and treatment based on national guidance and evidenced-based practice.
- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods of time.
- Staff assessed and monitored children and young people regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools. Children and young people were given pain relief in a timely way.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and research were proactively pursued.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide high quality, effective care.
- Key services were available 24 hours a day, seven days a week to support timely patient care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.



# Surgery

## Is the service caring?

**Outstanding**  

Our rating of caring improved. We rated it as outstanding because:

- Staff took time to interact with children, young people and their families in a respectful and considerate way.
- Patient and parent feedback was consistently positive. Children and young people told us staff treated them well and with kindness. Parents stated that staff go the extra mile and that the care their child received exceeded their expectations.
- Staff gave patients and their families emotional support and advice when they needed it.
- The trust had a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment.
- Staff understood the emotional and social impact that a patient's care, treatment or condition had on their wellbeing. There were initiatives across the service to improve patient experience.
- Staff communicated with children and young people about their care and treatment in a way they could understand. For younger patients, staff used toys and story books to help explain their care and treatment.
- Staff provided parents with relevant information, both verbal and written, so they could make informed decisions about their child's care and treatment.
- Patients and parents were both treated as important partners in the delivery of care. Parents were encouraged and supported to deliver their child's own care on the ward, this prepared them to support their child after discharge.

## Is the service responsive?

**Good**   

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and delivered care, in collaboration with other organisations, to meet the needs of patients.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.
- It was easy for children and their families to give feedback and raise concerns about the care they had received. The service treated concerns and complaints seriously. They investigated them, including the child and their families in the investigation of their complaint. Lessons learnt were shared with all staff to improve care and services provided.

However:

- Staff were unclear whether information leaflets were available in different languages and formats.
- The service was looking at ways to improve access to services, as referral to treatment times were below the England average.

# Surgery

## Is the service well-led?

Good  

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

- Leaders had the integrity, 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 children, young people, their families and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn this into action, developed with stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. The service promoted equality and diversity in daily work and provided opportunities for career development.
- Staff were focused on the needs of children and young people receiving care. The service had an open culture where children and young people, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks, taking action to reduce their impact.
- Leaders and staff actively and openly engaged with children, young people, their families, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations, locally and nationally, to help improve services for children and young people.
- 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.

## Outstanding practice

- The service had recently started using pioneering 3D heart modelling and virtual reality to support complex cardiac surgery. Use of a virtual reality model of a patient's heart has been shown to assist clinicians to virtually plan and practice complex procedures ahead of surgery, reducing the risk of complications and improving outcomes.
- In collaboration with a local acute NHS trust and university, the service successfully performed specialist fetal surgery, for a baby with spina bifida. This was the first time this surgery had been performed in the UK. In comparison to postnatal surgery for this condition, fetal surgery has been shown to improve short and medium-term outcomes, preventing damage to the baby's spinal cord in the last trimester of pregnancy.
- There were initiatives across the service to improve patient experience. These included a poet visited the surgical wards and created bespoke poems for patients. The trust had also recently employed its first full-time music therapist, providing patients comfort and opportunities for creative expression. These initiatives had been positively evaluated by children and their parents.

# Surgery

- The service participated in the Harvey's gang initiative, allowing children with complex needs and long-term conditions to become trainee biomedical scientists for the day. This helped children gain a better understanding of what happens to their blood samples.
- The trust had a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment. Play staff held blood parties using disco lights and sensory equipment to distract patients while they were taking blood.

## Areas for improvement

Actions the service **MUST** take to improve:

- The service must ensure medicines are stored safely and destroyed in line with legislation and the trust medicines management policies.

Actions the service **SHOULD** take to improve:

- Improve the timeliness of discharge summaries sent to the patient's GP.
- Continue work to improve referral to treatment times.
- Review and improve systems for equipment maintenance in theatres so that staff are assured all equipment is fit for use.

# Critical care

Good   

## Key facts and figures

Great Ormond Street Hospital has 42 ICU beds located in three critical care areas; these are neonatal (NICU); cardiac (CICU) and paediatric (PICU), all on the fourth floor of the variety club building. The PICU provides general paediatric intensive care and had 19 beds (of which 13-15 were open at the time of inspection). CICU provides cardiac intensive care and now has 23 beds, split across Flamingo and Alligator ward (where 15-17 beds were open).

NICU provides neonatal intensive care and although is a critical care ward, it is part of the neonatal core service and so not part of this inspection.

*(Source: Trust Routine Provider Request)*

At the time of the inspection there were a number of critical care beds closed as the directorate did not have sufficient staff. This is reflected in the report.

Critical care services at Great Ormond Street Hospital provide care to children and young people under the age of 18 requiring high dependency (level two) and intensive care (level three). Level two care describes patients requiring more detailed observation or intervention. This includes support for a single failing organ system or post-operative care, and those 'stepping down' from level three care. Level three care refers to patients requiring advanced respiratory support alone or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multiple organ failure.

We visited all critical care wards (excluding NICU) over three days during our unannounced inspection on 01 October to 03 October 2019.

We reviewed 10 patient care records and observed care being provided across all critical care areas. We spoke with five parents, we were unable to speak to any children or young people, and 33 members of staff including nurses, consultants, junior doctors, physiotherapists, pharmacists, dietitians, and administrative staff. We also reviewed the trust's performance data and looked at trust policies for critical care.

## Summary of this service

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

- The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- 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.
- There were significant vacancies in the nursing workforce, but critical care wards were mitigating this risk to avoid any negative impact on patient care.
- Patient records for the critical care wards were entered on an electronic records system. All ten sets of patient records we reviewed were fully completed and stored securely.

# Critical care

- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them using the trust's systems and processes. Managers investigated incidents and shared lessons learnt with the whole team and the wider service.
- During the inspection we saw staff treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they deliver to patients and family members, including being considerate to patients who were not conscious, during any interactions.
- Family members spoke very positively about the care their child received in critical care and how they were treated by the staff on the wards.
- Family liaison sisters provided keyworker support for families experiencing a bereavement or those needing additional support.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to assist patients access services.
- Families could access the family liaison service, a service staffed by senior nurses who worked across PICU and CICU. The family liaison service provided practical and emotional support to patients, parents, and other family members.
- It was easy for people to give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them, involving family members and shared lessons learnt with all staff.
- Staff we spoke with stated that the directorate leadership team were visible on the wards and approachable. We observed that critical care staff interacted well with the ward leadership team during the inspection and that they were approachable.
- At the time of our last inspection it was identified that there were tensions between nurses and doctors on the critical care wards. During this inspection we found an improved relationship between doctors, nursing, and allied health professionals (AHP). Staff were very positive about their colleagues and we observed a collaborative working culture in place between the various disciplines.
- Prior to the inspection we were informed that there had previously been some tensions within the nursing workforce. However, on inspection staff were positive about the nursing leadership. Staff stated that they felt there was now improved morale and that it felt like a different working atmosphere.
- There was an effective corporate governance framework in place which oversaw service delivery and quality of care. The service had systems and processes to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. The critical care research team was embedded within the running of the service and was involved in numerous local, national, and international clinical and academic research projects.

However:

- We observed inconsistent staff compliance with IPC best practice guidance in relation to hand hygiene.
- Resuscitation equipment on critical care wards was not consistently checked, which was not in line with guidance from the Resuscitation Council.
- Critical care wards had a significant turnover of its nursing workforce, which meant that since our last inspection many experienced staff had left the service.

# Critical care

- The availability of pharmacy cover on critical care wards fell below the levels recommended by the Society of Critical Care Medicine. Staffing for pharmacy, a known risk, was on the directorate risk register.
- On PICU we saw medicines cupboards and fridges within the medicine's room were unlocked. We also found some expired medicines which had not been segregated from medicines still in use.
- We were told by staff that medicine related incidents had increased since the implementation of electronic prescribing, which was also on the board assurance framework (BAF).
- At the time of our inspection all critical care wards had beds closed which was impacting on their ability to admit children requiring intensive care. Staff on the critical care wards and the directorate leadership team stated that this was due to the wards not having sufficient staff to meet the critical care staffing level standards. Data provided by the trust demonstrated that between the 02 and 30 of September 2019, of the 19 PICU beds, 13 to 15 beds were open. Similarly, 15 to 17 of the 21 cardiac intensive care beds (split across Flamingo and Alligator), were open.
- Availability of beds was a significant factor in the number of refused admissions to critical care wards. Staff we spoke with stated that the number of refused admissions was higher than the national average.
- Delayed discharges for clinically fit patients from PICU to the wards was a recognised issue and on the directorate risk register. It was acknowledged that these delayed transfers were having a negative impact on flow and capacity. To mitigate this risk there were daily bed management reviews in critical care. In September 2019, the trust had commenced a project focusing on internal trust discharges which involved clinical leads. This continued to be an issue and update notes on the directorate risk register stated that step down capacity on the wards was limited due to the lack of available nursing staff.
- Although staff were positive about their colleagues across all disciplines and the change in morale, staff were frustrated about some of the decisions taken by the trust. Particularly in relation to a change in the specialist nurse bank rates. All members of the multi-disciplinary team were aware of the impact this had had on the morale of the nursing staff. Many staff felt that this could have been a contributing factor in staff turnover in the past 12 months.

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- We observed inconsistent staff compliance with IPC best practice guidance in relation to hand hygiene. On occasion staff did not use hand sanitisers when entering or leaving the wards, or when moving between patient bays
- Resuscitation equipment on critical care wards was checked inconsistently, which was not in line with guidance from the Resuscitation Council. There were some days where resuscitation equipment was not checked.
- The available pharmacy cover on critical care wards fell below the levels recommended by the Society of Critical Care Medicine. Staffing for pharmacy was on the directorate risk register. Pharmacy cover on critical care wards varied between 1.6 and 1.8 WTE which was below the recommended level.
- Treatment rooms where medicines were stored were secured using swipe cards. On PICU we saw that medicines cupboards and fridges within the room were unlocked. We were told that access was controlled by the ward matron and the pharmacy department who authorised this access, in line with trust policy. However, we observed nonclinical staff also had access to the treatment room, and therefore the medicines.
- On PICU we found expired medicines including total parenteral nutrition in the fridge, which had not been segregated from medicines which were still in use.

# Critical care

- We were told by staff that medicine related incidents had increased since the implementation of electronic prescribing, this known risk was on the BAF and included mitigating actions.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply this training.
- The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff effectively managed clinical waste.
- 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.
- There were significant vacancies in the nursing workforce, on PICU this was 16%, while on CICU it was 12%. The critical care wards were mitigating this risk but it was having a negative impact on their ability to admit children and young people who required critical 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.
- Patient records for the critical care wards were entered on an electronic records system. All ten sets of patient records we reviewed were fully completed and stored securely.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them using the trust's systems and processes. Managers investigated incidents and shared lessons learnt with the whole team and the wider service.

## Is the service effective?

Good   

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

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- The hospital had a paediatric dietetics team, which included specialised paediatric dietician for both the PICU and cardiology. Children's nutrition and hydration needs were assessed and met through a range of clinical guidelines including the infant feeding guideline.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease their pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- During our inspection we observed positive and collaborative working relationships across the multidisciplinary team. Staff stated they worked well together, and this was supported by effective and approachable clinical leadership.

# Critical care

- Critical care staff provided advice to patients and families on managing their care after discharge. We observed staff from different disciplines advising patients on how to maintain their recovery after they had left the hospital, including clinical nurse specialists and family liaison workers.
- Staff understood the need to record consent, and the principles of ensuring that consent was informed when given. Staff clearly recorded consent to treatment in the patients' records as necessary.

## Is the service caring?

**Outstanding**   

Our rating of caring stayed the same. We rated it as outstanding because:

- During the inspection we saw staff treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they delivered to patients and family members, including being considerate to patients who were not conscious, during any interactions.
- Staff were understanding of the needs of working with children and young people, they were friendly and conscientious in their approach, putting the child at ease. We observed staff taking time to speak and play with children or soothe those who were anxious or distressed.
- Family members spoke very positively about the care their child received on the critical care wards and how they were treated by the staff.
- Following the inspection, the trust provided FTT data for critical care wards. Data showed that between September 2018 and September 2019, the average number of family members who were likely to recommend the service was 96%, which is above the trust's target.
- In the event of a patient death, the service followed up family members and invited them back to meet with staff. This offered an opportunity to discuss and identify any support they required and obtain feedback on the care they and their child received.
- Staff understood the impact that patients' care, treatment and condition had on their wellbeing and on the wellbeing of their families.
- Medical staffing on each of the critical care wards was two consultants on duty during the day shift: one lead consultant and a supporting consultant. The second consultant was available to provide additional advice and support to family members throughout the day. We observed the second consultant frequently took time to check in on families.
- The palliative care team worked collaboratively with the critical care staff and family liaison team to manage end of life patients to ensure the needs of the child, family and staff were met.
- Staff stated that psychologists and the directorate leadership team provided debriefs and emotional support for staff when they knew there would be a difficult or distressing bereavement. To support staff senior leaders had introduced weekly psychological support, this provided an opportunity to not only discuss those likely bereavements, but also emotional support for unexpected bereavements. Support could also be provided at a "pre-brief", for expected deaths, which allowed staff to be proactive in supporting children and their parents and arrange a commemoration if they wished.
- Family members were positive about the care their child received. They stated that staff were professional and welcoming and that they were kept well informed of treatment plans.



# Critical care

- The family liaison sisters provided keyworker support for families experiencing a bereavement or requiring additional support.
- Critical care wards held numerous events for families and children, as well as advertising the availability of trust wide family activities, supported by the play specialist, art therapists, and volunteers.

## Is the service responsive?

**Good** ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- Critical care wards had space at the bedside for one parent to stay, parent accommodation locally was guaranteed for both parents if their child was on a critical care ward. We observed information leaflets relating to accommodation were available throughout critical care wards.
- There was clear signage throughout the main hospital building, which meant it was easy for visitors to locate the critical care wards. The trust website provided useful information about the critical care wards, including visiting times, key staff and what treatments were offered on these wards.
- Staff were aware of how to access translation services if the child or family were unable to communicate in English. Some staff stated they spoke other languages so could offer some translation but would use interpreters where appropriate.
- In communal areas and throughout the critical care wards there was a range of information for parents to access specialist support and advise. This included for emotional and spiritual support, specialist health and social care input, and signposting to supporting charities. Critical care wards had produced a range of public information leaflets, all parents were provided with a pack of this information when their child was admitted to the critical care wards.
- The hospital chaplaincy and spiritual care team was available to meet the religious needs of children and their families. A duty chaplain was available on site seven days a week including evenings, and the service also offered a 24-hour, seven day a week on-call service.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to assist patients and their families access services.
- Families could access the family liaison service, a service staffed by senior nurses who worked across PICU and CICU. The family liaison service provided practical and emotional support to patients, parents, and other family members.
- All children and young people were seen by a consultant within 14 hours of emergency admission and had a consultant review twice a day. This was in line with the NHS England standards for seven-day services.
- Staff were positive about the quality of referral from the Children's Acute Transport Service (CATS). CATS was a specialist multidisciplinary team, which could rapidly transport critically ill children in the North Thames and East Anglia Regions to access intensive care.
- The clinical site practitioners (CSP) provided the critical care outreach service to other wards, 24 hours a day, seven days a week.
- CSPs were supported in providing the outreach service for discharged critical care patients by the intensive care outreach network (ICON). ICON staff consisted of experienced doctors, either at senior fellow or consultant level, and there would be one member of this team on duty on every shift.

# Critical care

- It was easy for people to give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them, involving family members and shared lessons learnt with all staff.

However:

- At the time of our inspection all critical care wards had beds closed which was impacting on their ability to admit children requiring intensive care. Staff on the critical care wards and the directorate leadership team stated that this was due to the wards not having sufficient staff to meet the critical care staffing level standards. Data provided by the trust demonstrated that between the 02 and 30 September 2019, of the 24 PICU beds, 13 to 15 beds were open. Similarly, 11 to 13 of the 21 CICU beds, and four to eight of the nine Alligator Ward beds, were open.
- Availability of beds was a significant factor in the number of refused admissions to critical care wards. Staff we spoke with stated that the number of refused admissions was higher than the national average.
- Based on the paediatric intensive care audit network (PICANet) data the trust was an outlier in terms of refused emergency referrals. Data provided by the trust showed that between April and June 2018 critical care wards refused 24% of referrals, compared to 6% nationally, between July and September 2018 35% of referrals were refused compared to 8% nationally and between October and December 2018 34%, of referrals were refused compared to 17% nationally.
- Delayed discharges for clinically fit patients from PICU to the wards was a recognised issue and on the directorate risk register. It was acknowledged that these delayed transfers were having a negative impact on flow and capacity. To mitigate this risk there were daily bed management reviews in critical care. In September 2019, the trust had commenced a project focusing on internal trust discharges which involved clinical leads. This continued to be an issue and update notes on the directorate risk register stated that step down capacity on the wards was limited due to the lack of available nursing staff.

## Is the service well-led?

Good  

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

- Staff we spoke with stated that the directorate leadership team were visible on the wards and approachable. We observed that critical care staff interacted well with the ward leadership team during the inspection.
- Staff knew the management arrangements and their specific roles and responsibilities. Nursing and medical leadership provided clinical support to staff, as well as leadership for the delivery of care and bed management.
- At the time of our last inspection it was identified that there were tensions between nurses and doctors on the critical care wards. During this inspection we found an improved relationship between doctors, nursing, and allied health professionals (AHP). Staff were very positive about their colleagues and we observed a collaborative working culture in place between the various disciplines.
- Prior to our inspection we were informed that there had been some tensions within the nursing workforce and issues with the nursing leadership. However, during our inspection staff were positive about the new nursing leadership. Staff stated that they felt there was now improved morale and that it felt like a different working atmosphere.
- Staff demonstrated an awareness of the trust's values which were displayed on the critical care wards. Critical care staff stated that the trust values were embedded on their wards.
- There was an effective corporate governance framework in place which oversaw service delivery and quality of care.

# Critical care

- The last four governance committee minutes included discussions about complaints, incidents, key performance indicators (KPIs), training, risk register, learning, issues from other health and safety committees, and other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the monthly critical care governance meetings. The meetings were minuted for dissemination to other staff who were not able to attend.
- The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- At the time of the last inspection, some risks had been on the risk register for over three years and minutes of the monthly critical care board did not demonstrate progress on resolving these. On this inspection we observed each risk on the risk register had an action plan to mitigate any potential risks to patients, and these were reviewed at least monthly in the risk action groups and reflected in an updated register.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. The critical care research team was embedded within the running of the service and was involved in numerous local, national, and international clinical and academic research projects.

However:

- The service had a business plan that identified aspirational targets and goals for the coming year but did not have a specific vision or strategy for the future of critical care wards. Senior staff recognised that there was not a long-term development plan for critical care, it was reported that this was for several reasons, including refurbishment of the space around PICU and NICU, as well as the lack of certainty around the number of beds that could be opened.
- Although staff were positive about their colleagues across all disciplines and the change in morale, staff were frustrated about some of the decisions taken by the trust. Particularly in relation to a change in the specialist nurse bank rates. All members of the multi-disciplinary team were aware of the impact this had had on the morale of the nursing staff. Many staff felt that this could have been a contributing factor in staff turnover in the past 12 months.

## Outstanding practice

- The senior leadership team had introduced weekly psychological support sessions that supported the ad hoc provision available, when they were aware of a possible bereavement. This approach ensured emotional support was provided at a “pre-brief”, which also allowed staff to be proactively supported and arrange a commemoration for patients if they wished.
- Family liaison sisters provided support to families during a bereavement or to those families needing additional support. In the event of an expected bereavement, the family liaison team worked proactively in collaboration with the palliative care team to provide additional support, and access to psychology support for families and siblings. This facilitated individual timely support at the level the family and siblings required.
- The critical care research team were embedded in the critical care areas working in collaboration with clinical and academic teams. They were involved in numerous local, national, and international clinical and academic research projects that had resulted in improvements to patient treatment and outcomes.
- Critical care staff were lead authors on four of the eight multiple centre trials published globally in paediatric intensive care in 2018 and 2019. They were the largest globally contributor from any the paediatric intensive care units.

# Critical care

## Areas for improvement

Actions the service **MUST** take to improve:

- Ensure medicines are stored safely, in line with legislation and the trust medicines management policies.

Actions the service **SHOULD** take to improve:

- Consider developing a directorate clinical strategy for critical care areas.
- Provide consistent checks in relation to all in use resuscitation equipment in the critical care areas, in line with guidance from the Resuscitation Council.

# Mental health services

## Background to mental health services

The Mildred Creak Unit is a ten-bedded inpatient service within the department of child and adolescent mental health at Great Ormond Street Hospital for Children. The service provides specialist care to male and female patients aged seven to 14 years with a range of complex social and emotional mental health needs, including somatising disorders (medically unexplained symptoms). Patients can access a range of psychological interventions and receive specialist support to manage their physical health.

Three beds are designated day beds. These beds are used to support an intensive home-based treatment package provided as an alternative to inpatient admission.

The trust is not registered to detain patients under the Mental Health Act. All patients staying on Mildred Creak Unit are there on an informal basis. Consent for care and treatment is given by patients and their parents. If patients require detention under the Mental Health Act, the service arranges their transfer to a specialist mental health hospital.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our inspection team for this core service comprised two CQC inspectors, a nurse specialist advisor and a CQC Mental Health Act reviewer. We inspected the service over two days.

During our inspection we:

- toured the ward area including the clinic room
- interviewed the ward manager and other members of the senior leadership team
- interviewed three registered nurses and one healthcare assistant
- interviewed the ward consultant psychiatrist and one junior doctor
- interviewed other members of the multi-disciplinary team including a social worker and child and adolescent psychologist
- interviewed five patients and three family members of patients
- reviewed the care records of six patients
- checked the prescription charts for every patient
- attended a community meeting and observed a staff meeting and handover

# Summary of findings

- and reviewed records relating to the overall quality of the service.

## Summary of mental health services

Good   

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

- The service provided safe care. The ward environment and all equipment used was clean and well maintained. The ward had enough nurses and doctors to provide support to patients. Staff assessed and managed risks well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff completed assessments of patients' individual needs. They provided specialist treatment to meet the needs of patients. Care was delivered in line with national guidance about best practice and the service had developed its own unique ways of working to meet the specific needs of patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward team had access to the full range of specialists required to meet the needs of patients. Staff received mandatory training, supervision and appraisal and regular reflective practice sessions to improve patient care. The ward staff worked well together as a multi-disciplinary team and with other services involved in each patient's care pathway.
- Staff treated patients with compassion, kindness, dignity and respected their privacy. Staff understood the individual needs of patients and put them and their families at the centre of care and treatment decisions.
- Staff planned and managed discharge well and liaised effectively with services that provided aftercare. As a result, discharge had not been delayed for anything other than a clinical reason.
- The service was delivered by leaders who worked effectively with staff to help create an open and supportive working culture.

However:

- Ineffective governance around the introduction of the new electronic patient record system impacted on the work of the unit. The new system did not meet the unit's needs. This had been recognised, but not promptly addressed. Staff could not record, update and find patient records promptly. Protocols and guidance for electronic patient record storage had not been implemented effectively.
- Two registered nurses were not competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years.
- Timely administrative support for the service was not in place; as resulting in completion of some audits had been delayed and some paper records were not available for staff to view.
- There was no disabled access to the roof garden terrace for staff, patients and family members, but staff arranged for all patients to have regular access to fresh air.
- At the time of our inspection patients did not have access to independent advocacy whilst the trust arranged a new provider.

# Child and adolescent mental health wards

Good   

## Key facts and figures

The Mildred Creak Unit is a ten-bedded inpatient service within the department of child and adolescent mental health at Great Ormond Street Hospital for Children. The service provides specialist care to male and female patients aged seven to 14 years with a range of complex social and emotional mental health needs, including somatising disorders (medically unexplained symptoms). Patients can access a range of psychological interventions and receive specialist support to manage their physical health.

Three beds are designated day beds. These beds are used to support an intensive home-based treatment package provided as an alternative to inpatient admission.

The trust is not registered to detain patients under the Mental Health Act. All patients staying on Mildred Creak Unit are there on an informal basis. Consent for care and treatment is given by patients and their parents. If patients require detention under the Mental Health Act, the service arranges their transfer to a specialist mental health hospital.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our inspection team for this core service comprised two CQC inspectors, a nurse specialist advisor and a CQC Mental Health Act reviewer. We inspected the service over two days.

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- interviewed five patients and three family members of patients
- reviewed the care records of six patients
- checked the prescription charts for every patient
- attended a community meeting and observed a staff meeting and handover
- and reviewed records relating to the overall quality of the service.

## Summary of this service

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

- The service provided safe care. The ward environment and all equipment used was clean and well maintained. The ward had enough nurses and doctors to provide support to patients. Staff assessed and managed risks well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.

# Child and adolescent mental health wards

- Staff completed assessments of patients' individual needs. They provided specialist treatment to meet the needs of patients. Care was delivered in line with national guidance about best practice and the service had developed its own unique ways of working to meet the specific needs of patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward team had access to the full range of specialists required to meet the needs of patients. Staff received mandatory training, supervision and appraisal and regular reflective practice sessions to improve patient care. The ward staff worked well together as a multi-disciplinary team and with other services involved in each patient's care pathway.
- Staff treated patients with compassion, kindness, dignity and respected their privacy. Staff understood the individual needs of patients and put them and their families at the centre of care and treatment decisions.
- Staff planned and managed discharge well and liaised effectively with services that provided aftercare. As a result, discharge had not been delayed for anything other than a clinical reason.
- The service was delivered by leaders who worked effectively with staff to help create an open and supportive working culture.

However:

- Ineffective governance around the introduction of the new electronic patient record system impacted on the work of the unit. The new system did not meet the unit's needs. This had been recognised, but not promptly addressed. Staff could not record, update and find patient records promptly. Protocols and guidance for electronic patient record storage had not been implemented effectively.
- Two registered nurses were not competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years.
- Timely administrative support for the service was not in place; as resulting in completion of some audits had been delayed and some paper records were not available for staff to view.
- There was no disabled access to the roof garden terrace for staff, patients and family members, but staff arranged for all patients to have regular access to fresh air.
- At the time of our inspection patients did not have access to independent advocacy whilst the trust arranged a new provider.

## Is the service safe?

**Good** ● → ←

Our rating of safe stayed the same. We rated it as good because:

- All ward areas were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves and followed best practice in anticipating, de-escalating and managing behaviour that challenged. Staff used restraint only after attempts at de-escalation had failed and minimised the use of restrictive interventions.



# Child and adolescent mental health wards

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the unit had a safeguarding lead.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The service had a good track record on safety and managed patient safety incidents well. Staff recognised incidents and reported them appropriately. There was a clear process in place to ensure serious incidents were investigated and any lessons learnt identified. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

Good   

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

### **Our rating of effective stayed the same . We rated it as good because:**

- Staff assessed the physical and mental health of all patients on admission and reviewed patient's individual needs and risks on a regular basis.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice where this existed. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised tools to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for all new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other teams within the trust and with relevant services outside the organisation.

However:

- Two registered nurses could not explain Gillick competence in relation to their role when treating patients aged under 16.
- At the time of our inspection an advocacy service was not available to patients staying on the ward. There were plans in place to reinstate the service using a new provider.

# Child and adolescent mental health wards

## Is the service caring?

Good ● ↓

Our rating of caring went down. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition, adapting their communication to make sure it was age-appropriate.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.
- Patients were also encouraged to support one another and engage in group activities as part of their recovery.
- Staff informed and involved families and carers in the decision-making progress. Parents gave positive feedback about the care and treatment patients received on the Mildred Creak Unit.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

### **Our rating of responsive stayed the same . We rated it as good because:**

- Staff planned and managed discharge well. They pro-actively liaised with services that provided aftercare and were appropriately assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was not delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. Patients could access a quiet space away from the main ward when needed.
- Staff ensured patients had access to the hospital school and their education needs were met.
- The food was of a good quality and patients could make hot drinks and snacks at any time, under supervision from the staff.
- The ward met the needs of all patients who used the service, including those with protected characteristics. Staff helped patients with communication, cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, and shared these with the whole team and the wider service.

However:

- There was a lack of disabled access to the roof garden terrace for staff, patients, family members and carers to use, although staff worked to ensure all patients had access to fresh air.

# Child and adolescent mental health wards

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- There was ineffective governance in respect of the introduction of the new electronic patient record system to this unit. It did not fully align to the needs of the unit. This was recognised, but it had not been rectified in a timely way. There was a lack of guidance and clear protocols for staff to follow to ensure the consistent storage and updating of records on the electronic patient record system.
- The service did not have access to timely administrative support and the completion of audits and document scanning was delayed.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the service they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in local and national quality improvement activities.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

### Child and Adolescent Mental Health services

The trust **MUST**:

- Ensure that the electronic patient record system meets the needs of the service, so staff can record, update and find patient records promptly. This includes further development of, and staff adherence to, electronic patient record storage protocols.

### Child and Adolescent Mental Health services

The trust **SHOULD**;

- Continue to take action so that staff, patients, family members and carers are not negatively affected by the lack of disabled access to the roof terrace.
- Provide training and support to all relevant staff so that they are competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years.
- Provide timely administrative support for the service, so audits and document scanning are not delayed.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

# Our inspection team

Fiona Wray, inspection manager led this inspection. Carolyn Jenkinson, Head of inspection and three executive reviewers, supported our inspection of well-led for the trust overall.

The team included five inspectors, two medicine inspectors, four specialist advisers, one mental health reviewer and an expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.