East Kent Hospitals University NHS Foundation Trust

Queen Elizabeth The Queen Mother Hospital

Quality report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected and information given to us from patients, the public and other organisations.

Overall rating for this hospital	**Choose a rating**
Services for children & young people	Inadequate

Letter from the Chief Inspector of Hospitals

We inspected services for children and young people at Queen Elizabeth the Queen Mother Hospital on 24 and 25 October 2018. The inspection visit on 24 October was unannounced and began at approximately 8.30pm.

This responsive inspection was undertaken because we had received concerning information from members of the public and staff about the Emergency department and children's inpatient wards. We had also identified concerns about the care of children during our May 2018 inspection when we inspected the emergency department and operating theatres but did not review services for children and young people as a separate core service.

As part of this inspection, we reviewed the care and treatment of children and young people from birth to 18 years in the two acute hospital sites with children's inpatient units. Some outpatient services for children are provided at the Kent and Canterbury Hospital site and from Buckland Hospital in Dover, but there are no inpatient services there. We did not inspect clinics or community services as the inspection was focused on the areas of concern.

We rated the children and young people's services at Queen Elizabeth the Queen Mother Hospital as Inadequate overall. We fed back our immediate concerns to the chief executive officer, the director of nursing and quality, the medical director and the quality improvement programme lead.

The services for children and young people were not safe.

- Resources for children and young people with mental health problems were not sufficient to ensure they, other children and staff remained safe.
- The recognition and management of deteriorating patients was inconsistent and senior clinicians did not follow the trust protocols or national guidance on the management of sepsis.
- People were at risk of cross infection of communicable diseases because of poor facilities and poor practice.
- Staffing levels were insufficient to meet the needs of children and young people.
- There was insufficient attention paid to safe medicines management.
- Incidents were not identified, nor reported and there was very limited learning from incidents.

The services for children and young people were not effective.

- The trust could not identify shortfalls in care nor benchmark their performance against other trusts as there was limited participation in national audits.
- Local audit results were inaccurate and there were conflicting results from different audits. An example of this was a report of sepsis that gave falsely positive information and which could not have been accurate based on the early warning scores contained within the report.
- Pain was not always managed in a timely manner.
- Fasting times before surgery did not follow current best practice and put the needs of the service before the needs of the children.
- Staff had no training in de-escalation techniques or managing children with mental health problems.
- Staff reported that staff shortages were such that they could not attend planned training.
- The trust did not resource children's services at Queen Elizabeth the Queen Mother Hospital in line with the current intercollegiate guidance.
- There were gaps in the seven-day service provision that meant children had to be treated in adult environments by adult staff.
- Out of Hours consultant cover did not meet the intercollegiate standards.

Improvements were needed in the care and compassion shown to children and families.

- Receptionists in the main accident and emergency department were sometimes offhand with parents of children. We observed that staff did not make eye contact nor smile at parents who were very anxious and needed reassurance.
- One receptionist told a mother of a visibly unwell child that she was lying about not being triaged.
- Senior staff used unfavourable stereotypes when describing parents, particularly those from specific areas.

The services for children and young people were not responsive.

- The flow of children and young people through the accident and emergency department was confused and not understood by staff.
- Senior staff and operational staff argued in front of the inspection team about which was the correct pathway for children to move through the department.
- Children were required to wait in the adult waiting area. This included at night when it was crowded and when some adults were likely to be drunk or volatile.
- The service for children with mental health problems was insufficient and failed to protect the children, other children or staff. Whilst this service was commissioned by the Clinical Commissioning Group from a third party, the inadequacy should have been addressed by the trust.
- There was limited provision for and a lack of understanding of the needs of children and young people with learning disabilities or autism.
- There were frequent breaches of the four-hour emergency department target.
- Urgent referrals were not always seen within the expected referral to treatment times.
- The journey to theatres had not been adapted to be child friendly.
- A lack of overnight accommodation for mothers of babies on the Special Care Baby Unit meant that establishing breastfeeding was more difficult, increased the risk of maternal mental ill health and was likely to impact negatively on mother and baby bonding.
- There was very limited consideration of the needs of young people aged 16 years to 18 years.

The services for children and young people were not well led.

- There was not a clear, well understood vision and strategy for the service.
- Governance and risk management processes were ineffective and provided false assurance to the board.
- Leadership was confused with a lack of oversight of all the children using trust services.
- Staff reports of the culture within the service were variable with some reporting bullying, oppression and not being listened to.
- The NHS Staff Survey results for 2017 showed that overall the trust was in the worst 20% of trusts nationally for staff engagement. The results had worsened for many key findings since 2016.

We saw several areas of good practice including:

- Parents reported very positively about the care and support the staff on the Special Care Baby Unit offered them.
- Child bereavement boxes had been purchased by the hospital charity for use in the emergency department when a child had died.
- The routine use of heel warming made heel prick blood testing less painful and more effective.
- Staff who were exceptionally busy dealing with a high demand and very sick children remained kind and gentle towards the children.
- Staff had a clear understanding of their safeguarding role and responsibilities and there was an effective system to provide prompt child protection medicals when needed.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Provide suitable accommodation for children and young people with mental health problems.
- Review their booking and triage processes to ensure all staff are clear about the pathway children take through the emergency department and to minimise the time before they are assessed by a qualified children's nurse.
- Ensure that equipment checks required by trust policies are carried-out.
- Ensure the safe management of medicines.
- Ensure that clinicians are aware and follow trust policy and national guidance on the safe management of deteriorating children, testicular torsion and sepsis identification and management.
- Ensure that children wait in the children's waiting area at all times. They must not be exposed to volatile behaviour, inappropriate television programmes and unpleasant sights and sounds in the adult waiting area.
- Review the care of children aged 16 years to 18 years and ensure that their needs are fully considered.
- Ensure submission of data to national audit programmes to allow benchmarking against other children's services and to drive improvements.
- Ensure that they adhere to a local audit plan and use the results to drive service improvements.
- Carry out a learning needs analysis for nursing staff working with children and young people to assist in identifying what training is necessary and where there are gaps in staff skills and knowledge.
- Ensure that staff are provided with the necessary training and support to ensure they can carry out their work competently.
- Ensure compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections. To include ensuring there are appropriate isolation facilities in the children's emergency department for children with communicable diseases.
- Review their policy and usual practice on pre-operative fasting for children to ensure it is aligned to national guidance.
- Ensure that up to date policies and protocols are available to staff.
- Ensure that the needs of children and young people presenting in mental health crisis are considered and met.
- Ensure the views of children and young people are taken into consideration to aid service provision and make sure the care and treatment meets their needs and reflects their preferences.
- Ensure that there are no breaches of the four-hour admission to treatment target for children attending the emergency department.
- Develop a clear vision for children's services that is recognised and shared by all staff caring for children and young people.
- Ensure that data and information provided to the board is an accurate reflection of the services being provided to avoid the risk of false assurance.
- Undertake an assurance review of their children's service to identify gaps in their assurance and governance processes.
- Ensure that there is clear, accountable leadership of services for all children from birth to 18 years (and beyond 18 years for looked after children and children in need).

Additionally, the trust should;

- Provide staff with training in the care of children and young people with autism and learning disabilities.
- Ensure that the pathway for providing care when a child dies is known and understood by all staff likely to be affected.
- Provide all staff including senior leaders with training in equality and diversity.
- Consider providing customer service training for reception staff in the emergency department.

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Professor Edward Baker
Chief Inspector of Hospitals

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Services for children and young people	Inadequate	We rated services for children and young people as inadequate at Queen Elizabeth the Queen Mother Hospital. Safety was a concern with insufficient action being taken when risks were identified. There was inconsistent care and recognition of deteriorating patients. The provision for children with mental health problems was under resourced and failed to protect the child, other children or staff. There were significant shortfalls in the prevention and control of infection and of medicines management. The trust did not consider the needs of children and young people as being paramount when planning and delivering services. The needs of children undergoing surgery, the needs of children with learning disabilities and the needs of 16 to 18-year-olds were particularly poorly considered. Staff workload was stretched beyond a sustainable level and this was evident in the interactions between staff and from some staff to patients. It was commendable that the children's emergency department nursing and medical staff continued to provide compassionate and gentle care to the children and their families when they were so busy. The oversight and governance of services for children and young people was weak. Inconsistencies and incomplete data meant there was false assurance to the board about the quality and safety of care provided.

Queen Elizabeth The Queen Mother Hospital

Inadequate

Detailed findings

Services we looked at
Services for children and young people;

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Background to Queen Elizabeth The Queen Mother Hospital

The trust became an NHS foundation trust in 2009.

Both William Harvey Hospital in Ashford and Queen Elizabeth the Queen Mother Hospital provide inpatient, assessment and day surgery care for children and young people. Both hospitals have a Special Care Baby Unit and hold outpatient clinics for children. William Harvey Hospital also has a Neonatal Intensive Care Unit. The trust also provides a range of services in different towns around East Kent for speech and language therapy, occupational therapy, physiotherapy and psychiatry.

Children and young people aged over 16 years are usually accommodated and cared for within adult wards and clinics. According to the trust policy, there is a flexible approach to this where young people over 16 years of age have specific needs that makes care in an adult environment unsuitable.

Children needing emergency treatment can be treated at the Accident and Emergency departments at William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital, Margate. Children in the Canterbury area with minor injuries (for example a suspected broken arm) can be treated at the Urgent Care Centre at Kent and Canterbury Hospital. The Kent and Canterbury Hospital can see children requiring emergency care between 9am and 4pm Monday to Friday. Outside these hours and at weekends children are seen at the emergency departments at either William Harvey Hospital or Queen Elizabeth the Queen Mother Hospital.

The Special Care Baby Unit at The Queen Elizabeth the Queen Mother Hospital has two high dependency cots, and 14 cots in total.

We have inspected the trust four times since 2014. Following the 2014 inspection, we recommended that the trust be placed in to special measures. The commission recommended the trust stayed in special measures following an inspection in 2015. The 2016 inspection tested the necessity for continued application of special measures. Following this inspection and a quality summit, the trust came out of special measures in March 2017 but was issued with requirement notices for breaches of regulations. Our most recent inspection in May 2018 rated the trust as requires improvement overall, an unchanged rating from the previous inspection.

NHS Improvement placed the trust in financial special measures in March 2017 because it was forecast to be in significant financial deficit and was not meeting its control total (the trusts year-end target against its budget).

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. The trust had been working on the Clinical Commissioning Groups and Sustainability and Transformation Partnership, to define the strategy, but it was not yet in place. The lack of a system wide strategy created a barrier to the trust's defining its own strategy and impacted the trust's ability to make decisions about the future, particularly about investment in estates and environments.

Demographically, the hospital serves a population with numerous socio-economic challenges and on average, health is worse in Thanet than in England. Life expectancy is lower than for England and there are health inequalities: in deprived areas life expectancy is five years lower for women and 10 years lower for men. Teenage pregnancies are high compared to the England average. Estimated smoking rates are average but death rates from smoking are significantly higher. Binge drinking is around the national average. Children are significantly less active than average. The population has a significantly higher than average rate of mental health problems.

The Office of National Statistics states that there are around 328,300 children living in Kent, which is approximately 21.7% of the Kent population. The Kent population is largely comprised of people of white ethnic origin with children and young people from minority ethnic groups accounting for 9.4% of the total under 18-year-old population. Using the "Children in Low-Income Families Local Measure", 16.5% of children in Kent are living in poverty. This is above the regional average but below the England average of 18% (Kent Safeguarding Children Board 2017)

This inspection was carried out in response to concerns about the care of children identified during the inspection that took place in May 2018 and other concerns raised directly with us.

Our inspection team

The team included a CQC inspector, assistant inspector and inspection manager and a registered children's nurse, a consultant paediatrician and a specialist nurse in the care of neonates.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- is it caring?
- is it responsive to people's needs?
- Is it well led?

Prior to the inspection we considered all the information about the care of children and young people at the East Kent Hospitals University NHS Foundation Trust. This included nationally available data, information obtained from the public or members of staff contacting us and information supplied by the trust.

The inspection considered the care of children and young people across all areas of the two acute hospitals with inpatient wards for children. On both sites, we considered the care of children attending the accident and emergency unit and in the operating theatres, the care of babies in the neonatal units and older children aged between 16 and 18 years who were, generally, cared for in adult areas of the hospital.

We inspected the Queen Elizabeth the Queen Mother Hospital on the 23 and 24 October 2018. The inspection visits were unannounced and included time spent in the hospital during the night shift.

We spoke with 28 staff, 16 parents or carers and 11 children to seek their views on the care they received. We reviewed the individual patient records of 20 children. We used direct observation and staffing rotas to confirm staffing levels in all areas we visited. We observed the care being provided to children and their families. The trust supplied us with documents which we used to review their performance and the effectiveness of their monitoring systems.

Facts and data about Queen Elizabeth The Queen Mother Hospital

East Kent Hospitals University NHS Foundation Trust is one of the largest hospital trusts in England, with five hospitals and community clinics serving a local population of around 695,000 people. They also provide some specialist services for a wider population, including renal services in Medway and Maidstone and a cardiac service for all of Kent based at William Harvey Hospital, Ashford.

The trust operates from five sites. It has three acute sites: William Harvey Hospital in Ashford, Queen Elizabeth the Queen Mother Hospital in Margate and Kent and Canterbury Hospital in Canterbury. Across these sites they provide a range of services including; urgent and emergency services, medical care (including older peoples care), surgery, critical care, gynaecology, services for children and young people, end of life care, and diagnostics. It also operates two community hospitals, the Buckland Hospital in Dover and the Royal Victoria Hospital in Folkestone

The trust has 1,030 inpatient beds across 49 wards. This includes 30 critical care beds, 48 children's beds and 49-day case beds. The trust receives over 200,000 emergency attendances, 158,000 inpatient spells and one million outpatient attendances. The trust cares for more than 2000 people every day. The QEQM

hospital has a total of 388 beds, providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services.

The Queen Elizabeth the Queen Mother Hospital is registered to carry out the following regulated activities,

- Diagnostic and screening procedures
- Family planning services
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

In the financial year 2017/2018, 6,921 live babies were born. In addition, 9752 babies, children and young people were inpatients in the NICU/SCBU and inpatient children's wards. A further 14109 (including new-borns) were inpatients on wards outside of Child Health. Children and young people also attended many outpatient appointments with 21476 for initial and review by acute paediatricians and a further 27278 seeing community paediatricians for both initial appointments or review. Children and young people attended 54024 appointments across the specialities within the trust.

The services for children and young people at Queen Elizabeth the Queen Mother Hospital were last inspected in July 2015 when we gave an overall rating of Requires Improvement.

Services for children and young people

Safe	Inadequate	🔴
Effective	Requires improvement	🟠
Caring	Good	🟢
Responsive	Requires improvement	🟠
Well-led	Inadequate	🔴
Overall	Inadequate	🔴

Information about the service

The children and young people's service at Queen Elizabeth the Queen Mother Hospital comprised a 20 bed children's ward with one high dependency bed. The children's ward cares for both medical and surgical patients. There is also a neonatal unit consisting of a 14-bedded level one Special Care Baby Unit (SCBU) which includes two high dependency beds and an outpatients' department. A number of clinics are held every week in the outpatients' department to see paediatric referrals and patients discharged from hospital requiring follow-up.

Within the children's ward there is a two bed Children's Admissions Unit (CAU) which was opened four years ago and is managed by a children's advanced nurse practitioner. This enabled a child to be assessed and treated promptly following a telephone referral directly to the paediatrician by the family doctor, to bypass the accident and emergency department, where there was usually a longer wait.

In the emergency department, there is a separate area for children which has a waiting area and three designated child treatment cubicles, there is also a designated child resuscitation bay in the resuscitation area. Children under the age of six months, after registering in the emergency department, are sent

directly to the paediatric ward. During the quarter July 2018 to September 2018 there were 354 children under the age of 16 years seen in the emergency department at the hospital. We were not provided with the figures for children aged 16 years to 18 years.

The hospital does not have paediatric intensive care support. Children under the age of 16 years requiring intensive care are transferred to a specialist paediatric unit. Children aged 16 to 18 years requiring intensive care support are cared for in the hospital's adult intensive care unit.

Summary of findings

We rated this service as Inadequate because:

- There was poor oversight and ineffective governance of services for children and young people.
- The information the board received was providing false assurance.
- There was an insufficient mitigation when risks were identified and steps to maintain safety were not introduced in a timely way.
- The recognition and initial response to deteriorating children was inconsistent and the tools were not properly utilised.
- There was insufficient resourcing, staff training and consideration of the needs of children and young people with mental health problems.
- The nursing and medical staffing levels were not in line with the recommendations of national guidance.
- The children's areas of the hospital were not secure.
- There was poor medicines management.
- Equipment checks were not undertaken in accordance with the trust policies.
- There was very limited consideration of the needs of children aged between 16 and 18 years of age. The preferences of medical staff were placed above the needs of the child.
- There was limited consideration of the needs of children undergoing surgery; the service was not delivered in line with the national guidance: *Standards for Children's Surgery* (2013).
- Incidents were not always reported and there was not a timely or sufficiently robust investigation when incidents were reported.
- There was limited learning from complaints, comments and incidents we reviewed. Dissemination of learning was not used as a tool to foster improvements in the quality of care.
- There was limited assessment of the quality of care through participation in national and local audit programmes.
- Infection prevention and control practice was poor and the risks of cross infection were significant.
- Some reception staff failed to respond appropriately to anxious and frightened parents and children in the emergency department.

However:

- Nursing staff who were working under extreme pressure maintained a kind and compassionate manner when dealing with children and their families.
- Child safeguarding training within the directorate met the requirements of the intercollegiate guidance.
- The staff on the SCBU received unanimous praise from the parents who we spoke with. They talked about being involved, being encouraged to hold their babies, being given good explanations and being given an opportunity to ask questions.
- Staff interacted well with babies and used different methods of distraction to keep them calm.
- Most patients and parents talked positively about the staff. Words such as lovely, funny, sweet, kind, patient, gentle and calm were used to describe them.

Are services for children and young people safe?	Inadequate

We rated safe as Inadequate because:

- The identification and reporting of incidents was poor with incidents not being identified and limited learning from investigations of incidents across the organisation.
- Staffing was below the national recommended levels in all areas where children were cared for, with particularly low staffing levels in the children's emergency department and theatres.
- There was poor medicines management and control.
- The environment was unsafe and not secure. This was particularly true for children and young people in mental health crisis.
- Infection prevention and control was poor with a lack of facilities to isolate children who were potentially infectious, insufficient staff to ensure proper cleaning of equipment between patients and poor hand hygiene.
- Since August 2017, staff had not been provided with training to help them meet the needs of children and young people in mental health crisis.
- There was inconsistent identification and management of children and young people at risk of deterioration.
- There was poor understanding of the national guidance and trust policy on the early identification and management of sepsis.

However:

- Data provided by the trust showed safeguarding children training rates for the Child Health and Emergency Medicine directorates at October 2018 were 96% for level 2 and 82% for level 3. This meant child safeguarding training within the directorate met the requirements of the intercollegiate guidance.
- There was always an anaesthetist on duty in the operating theatre suite when children were in the department, which meant there was always a member of staff with advanced paediatric life support training available.

Incidents

- The records for the specialist services divisional board for Child Health, dated 21 September 2018 showed a total of 51 incidents recorded across the trust. This figure does not apply to areas of the hospital where children are cared for but which are not accountable to the Child Health divisional board.
- There were multiple incidents relating to data protection, safe care and treatment, delays, medication errors and security. In the reporting period April 2018 to September 2018, there 45 incidents reported relating to the care of children under 18 years and children's services at Queen Elizabeth the Queen Mother Hospital.
- However, not all incidents that should be reported were being reported. There was only one incident where a breach of the four-hour target was recorded but we know from other information provided by the trust that such breaches occurred quite often.
- Of these 45 incidents, 31 were assessed as 'no harm'. All other incidents were recorded as low harm – including a cardiac arrest and delays in obtaining mental health assessments.
- Compliance with the six-week timescale for investigation was low with less than 10% of incidents being investigated within six weeks in between August 2017 and mid-January 2018. In March and May 2018, the compliance rate was below 20%. In the reporting year July 2017 to July 2018, the best performance against the six-week timescale was in February 2018, when 35% of incidents were investigated within the timescale.
- Actions from previous minutes on records for the specialist services divisional board for Child Health, dated 21 September 2018 did not show poor compliance with incident investigation as a concern that needed addressing.
- The trust reported incidents via an electronic reporting system.
- The chief nurse felt that the trust was, "middle of the pack" when compared to other trusts, in terms of incident reporting with about 1300-1400 incidents reported a month.
- The chief nurse was unable to identify any themes from incident reports and said they would have to check.

- Senior nursing staff told us that there were generic emails sent to key staff each morning detailing any incident involving the care of children under 16 years of age.
- The senior matron for children's services told us staff knew how to report incidents via the electronic reporting system but staff did not always complete incident reports because it was too time consuming and staff felt there was little value in doing this. Staff we spoke with told us they completed incidents reports but did not always receive timely feedback.
- We were told that individual staff reporting an incident were copied into the feedback emails.
- It was felt that ward staff had improved the frequency with which they reported incidents and that there had been some learning from slides shared at a team meeting.
- We were shown the emails that were circulated to key staff about incidents involving children. None had been reported from the previous evening when we were in the children's emergency department. We saw several occurrences that should have been reported via the incident reporting system but which were not. This included a quite sick child being lost on the electronic tracking after booking in to reception, a child kept in the department overnight (approximately 15 hours) and a doctor wishing to examine a baby but having no space available to do so. This demonstrated that staff were not reporting all incidents, there could be no learning or action to mitigate risks and the board were getting an incomplete picture of safety and performance.
- The chief nurse reported that the trust was strengthening learning from incidents through care group meetings, team meetings, six weekly matron meetings and specialist nurse's meetings with the chief nurse.
- Medically led mortality and morbidity meetings took place monthly. Individual cases were discussed and the discussions were recorded. There was some consideration of learning but where improvements to care were identified the action plans were vague and insufficient to make sure the necessary changes were made. There were no timescales, no person identified as responsible and no follow up to ensure the actions were implemented.
- Numerical mortality figures were reported to the board.
- The national NHS staff survey results (2017) showed that the trust performed poorly on the key findings associated with incident reporting and was in the worst 20% for three of the four measures. It was below average when compared to other trusts for the fourth measure.

Cleanliness, infection control and hygiene

- The specialist services divisional board for Child Health report dated July 2018 showed that there were no reported cases of either clostridium difficile or methicillin resistant staphylococcus aureus.
- On the Special Care Baby Unit (SCBU), the fridges were clean and expressed milk was stored in named and dated bottles. All bottles were sealed and within useable date.
- In the emergency department, we observed a nurse drawing up medicines for a child without washing their hands or using gloves.
- A student nurse in the resuscitation bay weighed a child without washing hands before or afterwards.
- There were no isolation facilities available to the staff in the children's emergency area. We observed a young child with chicken pox being asked to remain in the triage room which is off the main children's bay. The child was quite active and was seen running around the bay amongst other children to fetch a drink and toys. He had been waiting in both the main adult waiting area of the emergency department and the families waiting area.
- A locum doctor examining the child with chicken pox did not use any personal protective equipment and did not wash their hands after examining the child.
- A young person being cared for overnight in the children's emergency department was said, by the reviewing consultant, to have diarrhoea of infectious origin, possibly clostridium difficile, which is easily spread. The child was using the single available lavatory without any additional precautions being taken. They were in the open children's emergency department along with numerous other children and babies.
- There were no staff available to clean trollies or other equipment properly. The triage room was not cleaned after the child with chicken pox had been discharged.
- There was a protocol for the daily cleaning of toys within the children's emergency department. The records seen showed that the toys were not cleaned on 14 days during October 2018.

- On Rainbow ward there were cubicles available to isolate children who were at risk of contracting an infection or who were infectious.
- The *Annual Infection Prevention and Control Report* dated April 2017 to March 2018 stated that, "The Infection Prevention and Control team have continued to monitor standards of cleanliness within the trust and promote good practice in conjunction with the hospital and facilities managers through participation in the following activities: patient-led assessment of the care environment," advising contractors/contract management on cleaning and domestic issues and day to day advice/intervention/escalation to facilities management as appropriate, with regard to cleaning issues.
- There was no mention of audits against the national specification for cleanliness in the NHS, a key tool for monitoring the cleanliness of the hospital. Staff had not heard of this.
- The *Annual Infection Prevention and Control Report* dated April 2017 to March 2018 showed trust wide compliance rates for hand-hygiene/bare below the elbow and commode cleanliness were 92% for Child Health and 88% for accident and emergency.
- The report showed hand hygiene by medical staff at lower compliance rates than nursing staff with a composite score for medical staff in the urgent and emergency care division of 69.9% and specialist services (including Child Health) was 91.5%.

Environment and equipment

- The day surgery unit had a waiting area and four-bedded bay, separate from the adult areas of the unit. There were toys and a television in the waiting area.
- The main theatres ensured that children were prioritised on the list so that they were operated on first.
- The intercollegiate guidance document *Standards for Children's Surgery* 2013 states that in the recovery area, there should be a physical separation between children and adult patients and that parents/carers should be able to be present with their child when they wake up.
- The facilities at Queen Elizabeth the Queen Mother Hospital did not meet this standard. There was no separation of the recovery area for children in the day surgery unit but curtains were used to provide a degree of visual separation. The same applied to the main theatre recovery area where children were cared for alongside adult patients separated only by a curtain. When we visited the curtain was not fully closed. Children arrived at the theatre and were taken from theatre to recovery along a route that was used by adult patients and staff. It was busy and could have been frightening to a child.
- The entrance to the children's ward and children's emergency department had secured entry. There was a call button people could us to be let in. We noticed visitors could follow other visitors or staff in without being seen by a staff member.
- Exit from the ward was not secure with a low-down release button which was easily accessible to children. The senior matron was aware of this and said a project to make the exits secure was being introduced at William Harvey Hospital and would hopefully be followed up with similar at Queen Elizabeth the Queen Mother Hospital.
- The trust was not meeting the standards set in the intercollegiate document, *Facing the Future: Standards for Children in Emergency Care Settings* (2018). There was no suitable accommodation for the care of children and young people presenting to the emergency department with mental health crisis. The senior matron admitted there was nowhere to put such patients. They were cared for alongside physically unwell babies, children and young people in a cramped bay with four trollies posing a risk of exacerbation of the condition of the child with mental health problems because of the high stress, noisy, busy environment. There was also a risk that violent behaviour would be observed or impact on the other children present in the emergency department. When asked staff said they did their best.
- On Rainbow ward checks of the resuscitation trolley were completed daily. The weekly check of the sealed drawer contents was also completed.
- In the children's emergency department, the daily checks of the resuscitation trolley were frequently missed. During October 2018 there were eight days with no checks completed, in September 2018 there were 21 days with no checks completed. During August 2018 there were 12 days when checks were not completed.
- A resuscitation trolley audit was completed on 19 February 2018 which found several key items of equipment were missing.

- The *Integrated Performance Report* to the board, dated August 2018, showed that, across the trust, resuscitation trolley checks were only completed on 73% of the required days.
- Some of the equipment servicing and calibration was not completed within the due date.
- The door to the sluice was kept open on Rainbow ward presenting a risk of access by unsupervised children.
- On the SCBU all necessary equipment checks were completed and recorded daily. There was evidence that action was taken where there was missing or faulty equipment.
- The SCBU appeared clean and tidy, albeit cramped.

Medicines

- On the SCBU, we saw that medicine administration charts were completed. We looked at five charts and found that they all had the personal details entered in full, that allergies were noted and that they were written legibly in black ink with clear administration details.
- Also on the SCBU there were routine checks of the use and stocks of controlled drugs. These were correctly signed for and action taken when an anomaly was identified.
- On the children's inpatients unit, Rainbow ward, medicines charts were generally well completed, although there were some minor omissions such as the patient's hospital number and another record where there was a lack of clarity about the start date which had resulted in a missed dose.
- There was no topical anaesthetic cream in the paediatric resuscitation bay and the nurse had to leave the bay to find some to use.
- The children's emergency unit did not maintain stocks of controlled drugs but had to fetch them from the adult emergency care area.
- In the children's emergency unit, the medicines fridge temperatures were not recorded on 17 days in October 2018, 20 days in September 2018 and on 12 days in August 2018.
- Of those days where the fridge temperature was recorded, the fridge temperature records showed that the medicines fridge had exceed the maximum temperature of 8' centigrade for five days in August 2018, four days in September 2018 and five days on October 2018. The temperature recorded exceeded 13'centigrade on at least three occasions meaning staff could not be assured that the medicines remained effective and safe to use.
- The *Integrated Performance Report* to the board dated August 2018 showed that fridge temperatures were recorded 100% of the time, across the trust. The information being passed to the board was inaccurate.
- In the children's resuscitation bay, there were unlocked drawers where intravenous fluids were stored. There was a risk of unauthorised access and tampering.
- There was a drawer that contained both normal saline solution and a potassium solution closely located in very similar bags. This posed a risk of the incorrect intravenous solution being used in an emergency and serious consequences as a result.
- Another drawer contained a range of oral medication. This included a part used bottle of dexamethasone syrup that had expired in August 2018.
- There were also two bottles of paraldehyde and olive oil enema that were unlicensed drugs which had expired at the beginning of October 2018, prior to the inspection visit.
- The ward staff checked controlled drugs daily and any discrepancies should be escalated to the ward manager.
- On Rainbow ward there were four opened bottles of medicine. Three of the four had start dates on them, although one was unclear. We were told that the medicines were kept for three months once opened.
- The Rainbow ward fridge had five bottles of medicine which were all in date. The fridge temperature was checked each day and records showed this was routinely done.
- There were two out of date injection pens used to manage severe allergic reactions.
- When we reviewed the controlled drugs book, on Rainbow ward, we found some errors. These included no countersignature on one dose of 15% potassium chloride. There were also discrepancies involving a missing vial of midazolam and no signatures recorded. This was pointed out to the nurse in charge who suggested it was not their responsibility since it happened in the previous month. There was no suggestion this should be reported as an incident until they were prompted by the inspector.

- The *Local Risk Report* dated October 2018 highlighted a risk that there was an inability to prescribe chemotherapy to children via an electronic prescribing system, as required. This risk was entered on the register on 18 June 2018. The trust considered they had mitigated the risk through the use of pre-printed proformas with doses specified. All prescriptions checked by a pharmacist and prescriptions written by a limited number senior medical staff. There was an action of installing a fit for purpose prescribing system by May 2018 but no recorded updates relating to this.

Records

- The medical records on the SCBU were completed in line with national professional guidance. We reviewed three sets of case notes and saw that all entries were legible, signed and dated. They provided a comprehensive record of the care the baby had received.
- On Rainbow ward, individual patient records were kept in trolleys in the corridor. The trolleys were not lockable and there was a risk of unauthorised access of patient records.
- On Rainbow ward, we reviewed four sets of individual patient records. Most were comprehensive with clear plans recorded following review by a senior doctor. The exception was where a child was admitted under the care of the orthopaedic team when records were incomplete for the medical records, the nursing records and theatre records.
- In the children's emergency department, completion of the records was variable. A basic record was available but the record lacked detail sometimes. Not all sections of the forms were completed.

Safeguarding

- The *Local Risk Report* dated 29 October included an entry that stated, "Inability to meet statutory requirements for Safeguarding Children". The entry made clear that the staffing arrangements were insufficient although the report indicated that 1.5 full-time equivalent new band seven safeguarding advisors had been recruited and were due to start in January 2019.
- All incidents involving children under 18 years of age were seen by the named nurse for child safeguarding.
- The chief nurse for the trust sat on the Kent & Medway safeguarding children board.
- There was an automatic flagging system used across the trust which alerted staff to children presenting in the emergency department or Children's Assessment Unit about whom there were known safeguarding concerns.
- Notes from an early response meeting in relation to the deaths of children showed full, collaborative working between hospital staff and the Kent safeguarding children board stakeholders.
- There had been several child deaths in the emergency department within a relatively short period. Records indicated there was no link between the cases.
- The *Safeguarding Children team action plan* dated 2017 to 2018 showed most actions were complete or on track for completion within the timescales set.
- There was a Safeguarding Children team who provided both clinical and operational leadership for safeguarding children within the organisation. This team consisted of a named nurse, three other nurses, a lead midwife and three administrative staff.
- This medical provision was by two named doctors and a designated doctor for child safeguarding. The team sat within Child Health in the specialist division.
- The trust had a safeguarding children committee which met bi-monthly. This is chaired by the specialist services divisional nurse and is attended by the head of safeguarding children, the chief nurse and a representative from each division and the Clinical Commissioning Groups. This meeting reviews progress of actions identified from serious case reviews and the data which is necessary for statutory reporting, for example, FGM (Female Genital Mutilation).
- The head of safeguarding also attended the children's services improvement & assurance board and reported upon training compliance alongside the above issues.
- The information provided by the trust showed that child safeguarding training at the hospital did not meet the requirements of the intercollegiate guidance, *Safeguarding children and young people - roles and competences for healthcare staff* (2014).

- The Safeguarding Children team annual report for 2017 to 2018, showed trust wide compliance rates for safeguarding children training were 67% for level two, 61% for level three and 75% for level four. This was significantly below the trust target of 85%.
- Data provided by the trust showed safeguarding children training rates for the Child Health and Emergency Medicine directorates at October 2018 were 96% for level two and 82% for level three. This meant child safeguarding training within the directorate met the requirements of the intercollegiate guidance, *Safeguarding children and young people - roles and competences for healthcare staff* (2014).
- In line with recommendations from both national and local serious case reviews, supervision was available to all staff at the trust. This was supported by a policy for safeguarding supervision which was updated and reviewed in September 2016. Case holding staff, such as paediatric therapists, diabetic children's nurses and community midwives were required to attend at least three formal supervision group sessions in any 12-month period.
- Since September 2016, the Safeguarding team had undertaken weekly visits to the emergency departments to discuss cases that had caused concern to the staff; this year 1346 children or their parent/s were discussed. This was an increase of 222% from the previous year and provided assurance that supervision was effectively undertaken within this environment.
- The team provided advice and expertise to other staff at the trust through the operation of a duty system, Monday to Friday 9am to 5pm. Staff and outside agency partners received a prompt response when they had a safeguarding children concern.
- Non-attendance at health appointments is frequently recognised as a feature of the care of children who are killed or significantly harmed by their parents when these cases are reviewed. As part of a local serious case review, non-attendance at health appointments was identified, because of this, a review of how this was managed at the trust was undertaken by the head of safeguarding and head of child health services and consequently, a new trust wide approach was being adopted. This trust wide policy had superseded the previous Child Health 'did not attend' policy in recognition of the number of children that are seen across the trust by many specialities, and to provide consistency in approach within the organisation in relation to children not being brought to appointments.
- The prevalence of FGM in Kent is thought to be low due to the demography. Mandatory data recording and collection has been in place for the trust since September 2014.
- The trust had a policy in place within Women's Health, that had been updated and which identified the appropriate care pathways required for girls who have had this procedure undertaken. Additionally, guidance was updated this year within the current *Safeguarding Children Policy*.
- Very few of the nursing staff we spoke with understood the term FGM or Female Genital Mutilation and did not know they had an automatic, statutory responsibility to report it.
- The National Child Protection Information Sharing (CP-IS) project was implemented at the trust in a phased process commencing in January 2018. This system enabled staff to determine if the child had a child protection plan or was looked after by any local authority that is also part of the CP-IS programme. Staff in unscheduled settings such as the emergency department and children's wards were now able to access the system using their smart card.

Mandatory training

- Within the theatres at the hospital, 37 registered nurses and 65 operating department practitioners had completed training in paediatric immediate life support, as reported by the trust in June 2018.
- There was always an anaesthetist on duty in the operating theatre suite when children were in the department, which meant there was always a member of staff with advanced paediatric life support training available.
- In the emergency department there were always staff on duty who had completed paediatric immediate life support and advanced life support training.
- Clinical staff received limited training on how to recognise and provide a first response to children and young people with mental health needs, learning disabilities, or autism. A small cohort of staff received mental health training between April and August 2017. However, no further training had been scheduled which meant new staff to the trust had not had the opportunity to attend this training and those who had attended, had not received refresher training within the 12 months

prior to our inspection. This meant the trust did not have assurance that staff working with children and young people with mental health disorders were competent to meet the patient's needs.

- Staff completed nine mandatory training modules yearly. The trust set a target of 85% for completion of mandatory training. Trust data showed compliance to mandatory training for the Child Health directorate and emergency medicine as follows;
    - Equality and diversity 91%
    - Fire safety 86%
    - Moving and handling 91%
    - Information governance 83%
    - Health and safety awareness 91%
    - Infection prevention and control 93%
    - Safeguarding children level two 96%
    - Safeguarding children level three 82%
    - Hospital life support 69%
- Compliance to mandatory training was better than the trust target of 85% in six of the nine, only slightly worse for two modules and significantly worse in one module (hospital life support). However, the trust reported there were some inconsistencies in recording mandatory training, especially regarding hospital life support. The trust told us it was seeking assurance and clarification on this matter urgently.
- Records showed staff within Child Health also attended trust wide study days such as conflict resolution, adult safeguarding, adult mental health, first aid at work training and control of substances hazardous to health training.

Assessing and responding to patient risk

- The emergency department was using a Paediatric National Early Warning Score (PEWS) system for the monitoring of vital signs in children to highlight early signs of deterioration in the child's condition. There were different PEWS forms used depending on the child's age.
- The Paediatric Early Warning Score Report for September 2018 for Rainbow ward showed that compliance with proper completion of PEWS charts was poor. Thirty seven percent of PEWS charts were not scored accurately. The 'six early warning triggers' were not completed in 35% of cases. No blood pressure was recorded on 41% of first set of observations with no reason being given for 95% of these. Personal details and times and dates were sometimes missing and 4% of recorded observations were illegible.
- The actions identified in response to the audit had been shared with us in response to the findings but it did not make clear who was accountable, what the timescales were and some of the measures identified were not in place when we inspected.
- The Paediatric Early Warning Score Report for October 2018 showed poor recording of observations. Thirty three percent had no blood pressure recorded during the first set of observations, 14% of personal details were illegible, 14% had no recording or assessment against the 'six early warning triggers', 14% were not scored accurately. For children with a score of three or higher, the audit report showed that none had an action plan that was recorded and followed.
- On Rainbow ward, one registered nurse told us that they would need to obtain a consultant review if a child has a PEWS score of six or higher. The highest score possible on the trust PEWS charts is six and the policy suggests immediate senior review if the score is four or above. Not all staff were aware of the escalation that should follow a raised PEWS score.
- In the children's area of the emergency department we reviewed PEWS charts when we made an evening inspection visit. Of the five charts reviewed, none had a blood pressure recorded but had been scored appropriately in four cases. One child had observations recorded on a PEWS chart at 16.30pm but there were no further observations recorded until at least 9pm.
- In both the emergency department and on Rainbow ward we found photocopies of PEWS charts in use which did not provide the visual trigger of a coloured score area.
- In the emergency department, we noted a young baby with a previous NEWS score of five whose score was not totalled and who was still requiring oxygen to maintain their oxygen saturation level at 94%.

- We saw a 16-year-old child whose observation chart showed a National Early Warning Score (NEWS) score of three. The guidance on the NEWS chart for a score of three is for the nurse in charge and doctor to review the patients and for half hourly observations to commence. The patient should be screened for sepsis. This did not happen and the patient's observations were not recorded for a further two and a half hours.
- The trust and staff were not adhering to the Royal College of Nursing guidance standards for assessing, measuring and monitoring vital signs in infants, children and young people (2016) which states;
    - that practitioners take appropriate action in response to changes in vital sign assessment and measurement, where capillary refill time is included in vital sign assessment, recording and monitoring, practitioners receive clear guidance on its use and are given appropriate training;
    - there is a clear policy in relation to paediatric early warning systems, their use and limitations in either hospital or community settings;
    - there are policies and procedures, specific to infants, children and young people for monitoring vital signs post-operatively, during blood transfusions and during other therapies;
    - a stethoscope should be used to auscultate the apex heart rate of children less than two years of age;
    - electronic data should be cross-checked by auscultation or palpation of the heart/pulse rate and where oxygen saturation monitoring is indicated; and
    - respiratory assessment and measurement should be made and recorded simultaneously to give a complete respiratory assessment.
- The Child Health Patient Safety Action Plan provided by the hospital showed that one action was to, "Fully embed Sepsis 6 pathway across the trust". This action was shown as complete in September 2017.
- The trust had ratified the Guidelines for the Management of Sepsis in Children in August 2018. These guidelines were not followed.
- In the emergency department we found three different Sepsis six screening tools and pathways.
- A child under a year of age was directed to the emergency department by the 111 service who told the parents that the child needed to be seen within an hour as they had a high temperature and a non-blanching rash. They had booked in at reception and been given a form to complete but had waited 40 minutes in the adult waiting area.
- We observed the care of a child of three admitted to the paediatric resuscitation bay. He was clearly unwell with a pulse of 163 and a respiratory rate of 64. He required oxygen to maintain his blood saturation levels. He had been treated for an acute exacerbation in the ambulance with nebulised Salbutamol and Atrovent.
- Shortly after admission the child's observations were retaken and the temperature had increased as the pulse and respiratory rate. Using the algorithm for recognition, diagnosis and early management of sepsis in a child under five years of age in a hospital setting published in NICE guideline 51, this child should have had a sepsis screen completed as they met several of the 'Red Flag' high risk criteria.
- The guidance for such a situation it that there should be a review by a senior paediatric doctor and that blood tests should be carried out. The guidance is that intravenous antibiotics should have been given without delay (within a maximum of one hour). This did not happen and the registrar examining the child declined to take bloods and instead chose to send the child for a chest x-ray to "see if they had a chest infection".
- We spoke with a member of staff who had been present before the child went for an x-ray and who took over the care post x-ray. We asked why a sepsis screen had not been completed. We were told that they knew why the child had a very high temperature and that they had a fast pulse because they had been given Salbutamol. One staff member said, "We can't give every child that comes in with a high temperature and raised pulse antibiotics. It has to be down to professional judgement". We were also told this was in line with the trust policy on the identification and management of sepsis.
- We asked what happened if the child's condition continued to worsen over time. One member of staff told us that if there was no improvement within, "an hour or two" then they would consider sepsis.
- We saw that a sepsis screening tool had been completed retrospectively.

- The September 2018 Accident and Emergency Sepsis Report showed three children were screened for possible sepsis during the reporting period. They each had a PEWS Score of four or five but a sepsis Score of zero. It is unclear how the sepsis score of zero is calculated.
- The trust submitted a Prevention and Management of Deteriorating Patient Policy with a review date of April 2017. The trust told us that this policy had been reviewed and was taken to the policy group and ratified in May 2018 but required some formatting before it was made available. The policy that was shared with CQC was said to be current and within guidelines.
- This policy focusses on the recognition of deteriorating adults with only one mention to deteriorating children, to point the reader towards an example of a PEWS chart as an appendix. There is also a chart showing the trust sepsis screening tool. There was no scoring system for sepsis on the chart and it is difficult to see how a child could score four or five on the PEWS Scoring system but zero for sepsis. Six is the highest PEWS score a child can be assessed as and this includes a point for respiratory rate, temperature and pulse. The trust policy suggests 'red flag' warning signs of infection include raised temperature pulse and respiratory rate.
- The trust deteriorating patient policy suggests that if a patient has warning signs such as a raised pulse and respiratory rate and signs of a new infection (a cough is mentioned) then they should be treated for sepsis. This policy was not understood or followed by all staff.
- The guidance from the Royal College of Paediatrics and Child Health, Facing the Future (2015) states that every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned. Medical records reviewed showed that this was happening and the hospital was meeting this standard.
- We were told by the senior matron that the trust had a restraint' policy, which was introduced the week before our inspection and that staff were aware of the policy. The policy had been created in response to two recent restraint incidents, one of which involved six adults restraining an eight-year-old child.
- The policy was called the Therapeutic Holding policy and had been drafted with input from the child and adolescent mental health services provider with reference to the Royal College of Nursing guidance.
- Staff we spoke with were not aware of the restraint policy and their perspective about the appropriate action when faced with exceptionally challenging behaviour varied from calling security, trying to persuade the child to calm down and negotiate with them or keeping them isolated in a room until they had calmed down.
- The senior matron told us there was a recently introduced Absconding Child policy that had been the subject of a policy 'road test' with other involved agencies. There had been lots of learning that needed to be embedded. Staff we spoke with all had different views about how they should respond to a missing child or young person.
- We were told that the Leaving without Medical Advice policy was being re-written at the time of the inspection. The trust was working through potential ramifications and had included representation from the safeguarding team.
- We observed one nurse telling a patient's parent that they could leave if they didn't want to wait to see the doctor. The parent was concerned at the length of the wait and that her baby would need a feed shortly but no suitable formula was available in the department. No attempt was made to respond to the parents' concerns except to say that the department was very busy. The member of staff was not aware of a Leaving without Medical Advice policy.
- Children were offered a pre-assessment appointment either in person or by telephone. Observations were recorded on the paediatric surgical pathway form on the day of surgery.
- On the SCBU we observed nursing staff responded immediately to alarms sounding on monitoring equipment.
- The clinical leader for the SCBU had good oversight of the medical needs of the patient's and worked within clear referral pathways to tertiary centres.
- The children's emergency department was not staffed for children from 2am until 8am each night and sometimes longer. Children were then cared for in the main adult emergency department.
- Senior staff in the emergency department told us that it was very unusual to keep a child overnight in the department. They acknowledged that there were delays in treatment and that 'black breaches' were commonplace. Black breaches are delays of over 60 minutes from the when an ambulance arrives to the patient being formally handed over to the hospital. There had been two children who remained in the department for over four hours on the preceding day.

- Data provided by a member of staff from an incomplete audit showed that the introduction of a streaming nurse had resulted in delayed triage and treatment rather than shortened time from booking to treatment. This was at William Harvey Hospital but the issue was common to both sites. *Facing the Future: Standards for Children in Emergency Care Settings* (2018). Recommends that children are triaged and have a clinical assessment within 15 minutes of arrival in the department. The streaming process and staffing levels had resulted in delayed triage, potentially leaving sick children unidentified.

Nursing staffing

- The trust reported the paediatric staffing levels in the emergency department in June 2018. The response to an information request made as part of a wider inspection of the emergency department said, "we have provided a paediatric trained nurse to cover 24 hours per day in the paediatric ED. This person is supported by another trained nurse (adult or paediatric) between midday and midnight (our busiest time). They are also supported by an ED clinical technician or healthcare assistant 24 hours per day. This was not happening within the emergency department at Queen Elizabeth the Queen Mother Hospital. For example, on Sunday 21 October 2018 there was a children's nurse working a long day from 7.30am until 6pm with support from an agency children's nurse between 4pm and midnight. There were no children's nurses in the department between midnight and 7.30am on the 22 October.
- On Tuesday 16 October, there was a children's' nurse working from 7.30am until 6pm. They were supported by an agency member of staff working 10am until 11pm. There were no children's nurses in the department between midnight and 7.30am the following morning.
- On 18 September 2018, there was an agency children's nurse working alone from 7.30am until 8.30pm with another children's nurse working from 10am until 10.30pm and an unqualified member of staff working a twilight shift.
- On 21 September there was an agency children's nurse working from 7.30am until 8.30pm with another children's nurse working from 4pm until 11.30pm.
- Whilst we were on site, there were times when staffing had a significant impact on the running of the emergency department. At one point a nurse was needed to transfer a child to the ward, whilst another child needed accompanying to x-ray as they were quite unwell. There were two nurses on duty and both were also covering the triage of all children presenting in the department.
- At another point the children's trolley area was left without a nurse as they needed to print off some information and so had to go to an office.
- The deputy director of nursing for the Queen Elizabeth the Queen Mother Hospital understood that staffing levels were impacting on care and helped by taking a child to a ward. This was appreciated by staff but was not best use of their time and skills.
- We spoke with several band five and band six nurses working in the emergency department. They all told us that they routinely missed breaks, had no drinks and worked well beyond their contracted hours. We were told of a nurse working a 14-and-a-half-hour shift during the previous week as they felt it was unsafe to leave their colleague with so many sick children to care for.
- Another nurse told us they had stopped working in the emergency department. They said they were concerned that from 10pm there was only one children's nurse on duty even if the unit was busy. They pointed out that after 2am there were no children's nurses in the department.
- The Children's Assessment Unit had planned staffing of one band seven advanced nurse practitioner and a band five nurse. We were told that the band five nurse was often taken from the unit to provide support to the emergency department or ward. This left a situation where the advanced nurse practitioners could prescribe drugs but then there was nobody to administer them and delays in commencing treatment were inevitable.
- The advanced nurse practitioner also carried a paediatric resuscitation bleep but this meant they could be called anywhere in the hospital from the Children's Assessment Unit. If they were working alone, they could not attend the emergency call.
- The charge nurse in the main theatres was unclear about the arrangements for staffing theatres for children and told us that no surgery on children took place in the main operating theatres. Later, the same charge nurse confirmed that they did provide emergency and trauma surgery.

- Neither the main theatre nor the day surgery theatre used paediatric trained staff in the theatre or recovery areas. We were told the sister in charge, “was working on this” but it was not clear what that meant in practice.
- In the day surgery unit, there were two children’s nurses on duty in the ward area to provide care to children. There were no children’s trained staff in theatres or recovery.
- Staffing to provide safe care to children and young people with mental health needs was insufficient. Health care assistants with no training in supporting children with mental health needs were asked to special the child, if there were sufficient staff.
- In the emergency department there were no additional staff to meet the needs of children with mental health needs. We were told sometimes security were called and sometimes parents just had to cope. In the most difficult cases, the police were called.
- Staffing on Rainbow ward on the evening of the 22 October 2018 was adequate. There were three band five nurse (one of whom was an adult trained nurse) and one healthcare assistant with seven children at 8.50pm. The ward could accept up to 20 patients including one child needing high dependency care.
- We reviewed the rota for Rainbow ward and could see that the staffing levels were not always sufficient for the number of sick children being cared for. On Sunday 14 October there were two registered nurses off sick and they were not replaced. Three nurses worked a long day from 7.30am until 8.30pm with one healthcare assistant. There was also one member of staff covering the Children’s Assessment Unit. There was no play specialist support. On the night shift there were three registered nurses. The nurse on the assessment unit was based in the emergency department, so could not support the ward staff.
- On Sunday 21 October 2018, there were three registered nurses on during the day, supported by a healthcare assistant and two registered nurses during the night. We spoke with one nurse who was working on this date and were told that it felt unsafe as it was so busy and the children were quite ill. They hadn’t been able to take breaks at all. Two members of staff for 20 sick children is not in line with the national recommended staffing levels. The Royal College of Nursing guidance document, “*Defining staffing levels for children and young people’s services* (2013)” recommends that for children less than two years of age there should be a ratio of 1:3 registered children’s nurses to child both day and night. For children over two years of age, this ratio decreases to 1:4 registered children’s nurses to child, both day and night.
- The guidance says that the ward staffing complement must also have a supervisory ward sister/charge nurse and unregistered staff, who are not included in the above baseline bed side establishment. All general inpatient wards should have at least one band seven ward sister/charge nurse. In addition to the band seven ward sister/charge nurse, a competent, experienced band six children’s nurse is required throughout the 24-hour period to provide the necessary support to the nursing team.
- The *Local Risk Report* dated 29 October showed the nurse staffing arrangements for the SCBU did not meet the recommendations contained in the document, *Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A BAPM Framework for Practice* (2018). The unit was fully established but there remained a shortfall and agency staff or substantive staff working overtime were used to fill gaps. A business case for additional staff had been approved in 2016 but had not been fully implemented.
- Senior nursing staff told us a business case had been approved for increased staffing and they were now able to recruit additional staff including 5.64 health care assistants (there were none in the children’s emergency department at the time of the inspection). Also, three band six nurses and 5.19 band five nurses. The trust struggles to recruit qualified staff but when filled, these additional posts should improve the situation for frontline staff. They do not, however, mitigate the risks of current low staffing levels.
- There was no acuity tool in use by children’s services to assist in planning staffing levels. The Royal College of Nursing guidance document, *Defining staffing levels for children and young people’s services* (2013) states patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels.
- The staffing data for April 2018 downloaded from the trust website showed that the overall shift fill rates were below establishment on Rainbow ward with shortages in the shift fill rate for care staff. The registered nurse shift fill rate was shown as above establishment. There was an overall deficit in the actual patient care hours compared to the planned patient care hours.

- There were no figures for the published staffing data dated April 2018 for the children's emergency department.
- The skills mix in the emergency department and the children's outpatient areas were not developed with the best use of staff skills nor consideration of risk and acuity. In the children's emergency department there were no healthcare assistants or support staff to assist with routine tasks such as cleaning trolleys or taking observations. Children's nurses were trying to do these tasks in addition to meeting the higher level clinical needs of the patients and triaging. The Royal College of Nursing guidance document, *Defining staffing levels for children and young people's services* (2013) states that support roles should be used to ensure that registered nurses are used effectively.
- The children's outpatient area was managed and staffed by healthcare assistants without oversight from a registered nurse. The Royal College of Nursing guidance referred to above also states that there should be a minimum of one registered children's nurse available at all times to assist, supervise, support and chaperone children.

Medical staffing

- The anaesthetists providing care to children during the perioperative period were always children's trained consultant grade anaesthetists.
- We observed the medical handover for children's services at 8.30am. The round started on the SCBU where all the babies were discussed and any concerns such as safeguarding risks and discharge planning were considered.
- On the day of our inspection visit there was a consultant paediatrician (the neonatal lead) and a foundation year two doctor on the SCBU. One doctor was off sick but after consideration of the acuity levels it was decided that the arrangements were adequate. There were no advanced nurse practitioners working on the unit when we inspected.
- The trust reported all paediatricians working within the level one SCBU had received training in neonatology. There was an experienced middle grade doctor on site who covered the acute paediatric and neonatal areas.
- The *Local Risk Report* dated 29 October showed that the medical oversight of the neonatal service at Queen Elizabeth the Queen Mother Hospital was unsustainable. A specialist registrar was allocated to the service and there were attempts to recruit to the vacant consultant paediatrician role but this had not been achieved at the time of the inspection, and the risk remained.
- The hospital did not meet the recommendations in the Royal College of Paediatrics and Child Health, *Facing the Future - Standards for acute general paediatric services*. The recommended standard is that a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week. The explanatory notes to the guidance suggest this should be that a consultant paediatrician is present and readily available in the hospital for a minimum of 12 hours a day, seven days a week, with extended evening working until 10pm.
- On the children's inpatient unit there was a consultant and a registrar and a foundation programme doctor. A consultant was available on the ward until 5pm but some consultants chose to stay until 9pm.
- Locums were used to cover the middle grade shifts. Generally, these were the same three locum registrars.
- One consultant said there was no administrative support which meant letters and communications with GPs and others was often delayed. Letters from consultants were also often delayed by workload which resulted in delays to treatment starting for some children.
- We were told that there was no management support to find medical cover, when needed and the consultants spent their time finding doctors to cover.
- At weekends, from 5pm Friday to 8am Monday, there was one registrar and two more junior doctors covering SCBU, Children's Assessment Unit, the ward, emergency department and the labour ward.
- Overnight there was one registrar and a junior doctor with a consultant on call providing cover to the children's ward, the labour ward, the SCBU and the emergency department.
- Whilst observing in the paediatric resuscitation bay in the emergency department, we noted that the registrar leading the management of an unwell young child had to answer his bleep and make a call to the ward.

Safety Thermometer

- Ward managers submitted safety thermometer data electronically once a month. However, staff reported the safety thermometer did not mean a lot to paediatrics as their outcomes were measured in a different way. Senior staff received feedback about safety thermometer performance and we saw this displayed in ward areas.
- At 30 October 2018, none of the 718 children using the trust services had developed a pressure ulcer, experienced a fall or developed a urinary tract infection following catheter insertion.

Major incident awareness and training

- There were, very occasionally, times when Rainbow ward could not accept further admissions. Senior staff could talk us through the arrangements for transferring stable children to William Harvey Hospital in Ashford but this had not been necessary in the preceding 18 months.
- Where a recent outbreak of a potentially serious infection had occurred on the SCBU the multi-agency protocol had been followed correctly and all agencies worked together to ensure the closure was not prolonged. Measures had been put in place to protect the babies already admitted, the unit closed to further admissions and arrangements were put in place to ensure they were transferred, if necessary.

Are services for children and young people effective?

Requires improvement

We rated effective as Requires Improvement because:

- Many policies were out of date.
- The trust failed to follow the intercollegiate guidance on the care of children undergoing surgery.
- Trust polices were not well known (testicular torsion) and not adhered to (sepsis).
- There was a lack of clinical audit to inform service improvements.
- Information from previous audits such as the 2016/2017 Asthma audit and the 2015/16 Vital signs audits showed poor performance with the trust not meeting any of the standards. Later information was not available.
- Pre-operative fasting times for children waiting for surgery were not in accordance with the current national guidance from the Royal Colleges. Children and babies sometimes waited excessive times without fluids or food.
- There was no registered children's nurse working in the children's outpatients' department. This was not in line with the national guidance.
- There was not a children's nurse, who held a postgraduate qualification in emergency care or trauma, on duty at all times in the children's emergency department.
- There was no play specialist employed in the children's emergency department.
- There were no children's nurse to care for children in the operating theatre or recovery area.
- The trust was not staffed to provide a seven-day acute paediatric service.

However:

- There was good support for mothers who wished to breastfeed whilst their baby was admitted to the Special Care Baby Unit (SCBU).
- The trust performed in line with other similar trusts in the National Neonatal Audit 2017.
- The staff understanding of consent was sound.
- Staff appraisal rates were better than the trust target of 85%.
- Newly appointed nursing staff were supported into their role by having supernumerary time, completing an induction and participating in a preceptorship programme.

Evidence-based care and treatment

- The neonatal and children's services did not have Baby Friendly Initiative accreditation but were keen to work towards this. The UNICEF UK Baby Friendly Initiative was launched in the United Kingdom in 1995 to work with the NHS to ensure a high standard of care for pregnant women and breastfeeding mothers and babies in hospitals and community health settings.
- A 'New-born Infant Physical Examination' (NIPE) smart system was in place and was working well to ensure that neonatal screening and referral pathways existed. This included a mechanism that meant that babies not screened within 72 hours of birth would be identified. Trust performance indicators showed us that the trust had achieved a 95.4% target of NIPE examinations, which was slightly better than the target of greater than 95%.
- On the SCBU was a folder that contained many out of date protocols. This included the protocol for identification and management of Group B Streptococcus. This infection may be passed from mothers to babies during birth and for the majority is harmless but some babies develop serious symptoms. This policy had expired in 2016.
- The protocol for Neonatal Blood Spot Screening was also contained in the folder but had expired in 2014. The NHS new-born blood spot screening programme helps identify several rare but serious diseases with a small blood sample, also called a heel prick test.
- When we asked a ward sister about the out of date policies in the folder we were told they were no longer in hard copy but were available on the intranet. The policy for Neonatal Blood Spot Screening available on the intranet was the same version that had expired in 2014 but the GBS protocol had been updated and was due for review in 2020.
- We saw some protocols relating to the care of neonates that had expired on the intranet. These included Therapeutic Cooling (2013), Electrolyte Management (2011), Seizure (2011). In all, we saw 26 policies and protocols that were out of date between 2011 and 2017.
- Staff we spoke with were unclear about where to find the most recent policies when we asked and using the ward folder versions of the protocols posed a risk that they were not following the most recent guidance.
- There had been a serious incident reported where a testicular torsion had been misdiagnosed because the national clinical guidance had not been followed. The action plan had resulted in a new, simplified, pathway and we had been told this was embedded in practice. We spoke to junior doctors, advanced nurse practitioners and emergency department nursing staff about the new torsion pathway. None were aware of it. Most staff did identify that if a torsion was suspected it needed a surgical referral but were less clear about when they might suspect a torsion.
- As detailed under the assessment of deteriorating patients, senior medical and nursing staff were not adhering to the national guidance and trust policy on the identification and management of sepsis.
- The trust had implemented weekly audits of patient identification wristbands on Rainbow ward. From data supplied by the trust we could see that these were not completed weekly and that only 11 weeks of a possible 30 between April 2018 and October 2018 had been recorded. This was despite poor compliance rates, with only 40% of wristbands being in place, that were checked for in the week beginning 1 May 2018.
- Clinical audits were not being completed and many national audits were carried forward which meant there was no current performance indicators for the trust against national standards, and that the trust could not benchmark their performance against other trusts.
- The intercollegiate guidance, *Standards for Children's Surgery* (2013) was not being followed. There was no recognition of the psychological needs of children and young people in the operating theatre environment.

Pain relief

- A paediatric pain audit was being undertaken at the time of the inspection but the results were not yet available.
- Parents and patients on the ward told us that they sometimes had to wait or remind staff about pain relief.

- We observed one child in significant pain (that later required opiate analgesia) to be left in the adult waiting area without being assessed or offered analgesia for an hour. *Facing the Future: Standards for Children in Emergency Care Settings* (2018) states that children should be assessed and receive analgesia within 20 minutes of arrival.
- Most children were given analgesia shortly after triage in the children's emergency department.
- On the SCBU heel warming was used prior to taking blood using a lancet. This resulted in greater success, less lancet wounds and less pain for the baby.

Equipment

- The equipment in the high dependency beds for children was not checked on nine occasions in October 2018 and 12 occasions in September 2018.

Nutrition and hydration

- The trust had a policy on infant feeding and baby weighing. Staff we spoke with spoke positively around supporting mothers on their feeding choices.
- On the SCBU we saw that fluid charts were completed. We looked at six charts and found that they all had the personal details entered in full, that they matched prescribed intravenous fluids on the medicines chart and that they were written legibly in black ink with clear administration details. The quantity of fluids given and the baby's output were added up to allow good oversight of their fluid balance to support early identification of complications.
- On the children's inpatients unit, Rainbow ward, we looked at five fluid balance charts. They were generally completed although on one young child's chart the input was recorded (including intravenous fluids) but the output wasn't. This presented a risk that the overall fluid balance could not be calculated.
- In the emergency department paediatric resuscitation bay, we saw a young child with a high temperature was given a drink of squash and encouraged to drink.
- The nursing staff on Rainbow ward did not know or follow the intercollegiate clinical practice guidelines for pre-operative fasting which state, 'Intake of water and other clear fluid up to two hours before induction of anaesthesia for elective surgery is safe in healthy children, and improves patient wellbeing'. Ward staff told us that the fasting guidelines they gave parents was for children to have clear fluids until 6.30am for a morning list and until 11.30am for an afternoon list. This had potential to leave a young child up to about five hours without a drink.

Patient outcomes

- In the 2016/17 Moderate and Acute Severe Asthma report, Queen Elizabeth the Queen Mother Hospital failed to meet any of the standards. The hospital was in the upper quartile for one standard (when compared to the England average) and the lower quartile for two standards.
- In the 2015/16 Vital signs in children audit, Queen Elizabeth the Queen Mother Hospital failed to meet any of the standards. The hospital was in the lower quartile for two fundamental standards and four developmental standards.
- There was no data for the trust for the National Paediatric Diabetes Audit 2016-17 contained in the information available from the Healthcare Quality Improvement Partnership.
- In the 2017 National Neonatal Audit, based on data for January 2016 to December 2016, the hospital performance was within the expected range nationally.
- The trust Audit Plan 2018/2019 showed that several national audits were carried forward from the preceding year. These included Feverish Children; Cystic fibrosis re-audit; Feeding clinics; Audiology referral for raised Gentamicin levels and the ASD Diagnostic pathway.

Competent staff

- We were told it was very difficult to allow staff to be released for training as staffing levels were so low.
- On Rainbow ward, the nurse in charge on the day shift was unaware of children who had been admitted overnight which meant they were not able to have oversight of their care and treatment.

- Healthcare assistants were deployed according to their level of competency and experience. We were told band four healthcare assistants did everything except medicines. This was not in line with the current intercollegiate guidance, *Standards for Children's' Surgery* which recommends that children are cared for by children's trained nurses throughout the surgical pathway.
- The trust was not meeting the recommendations of the intercollegiate guidance, *Facing the Future: Standards for Children in Emergency Care Settings* (2018). There were not two children's nurses with recognisable post-registration qualifications in trauma and emergency medicine on shift at all times. Furthermore, emergency clinicians with responsibility for the care of children had not received training in how to assess risk and immediately manage children's mental health needs and support their family/carers. Training was not provided that included risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity.
- *Facing the Future: Standards for Children in Emergency Care Settings* (2018) states that all children's emergency departments should employ a play specialist. There was a play specialist on Rainbow ward but there was no dedicated play specialist for the emergency department.
- While there was a very recent policy on restraining children which focused on the principals and not the practice; there was no training around this and that posed a risk to children.
- The trust offered preceptorship support and training for newly qualified staff which entailed a year where there was allocated time for study and competency assessments.
- Newly appointed nursing staff had a two-week induction and supervision period where they were supernumerary.
- Minutes of the Child Health board for August 2018 showed that the appraisal rate was 83%, across the trust not split by staff group or site. The target was 85%.
- The five-month total to June 2018 showed that the acute children's team at Queen Elizabeth the Queen Mother Hospital had an appraisal rate of 89%; Rainbow ward was 92%. The SCBU rate was 86% for the same period.

Multidisciplinary working

- Local perinatal mortality meetings were held that considered all perinatal deaths. The minutes of the meeting held on 19 October 2018 showed that a root cause analysis investigation was carried out. The minutes showed there was no neonatal palliative care guidance for the trust and said it needed to be formulated, but his was not entered as an action. There was also a comment that there needed to be learning regarding signs of life but there was no action or identified person to lead on this on the minutes.
- Access to psychiatric support was very limited.
- Ward rounds were not multidisciplinary but medical led. The pharmacist and nurse in charge did not attend.

Seven-day services

- The children's assessment unit (which was adjacent to Rainbow ward) was open from 9am to 9pm Monday to Friday. Outside these times the advanced nurse practitioners worked from the children's emergency unit and supported staff there. Children who should have been seen on the children's assessment unit after referral from a GP, midwife or health visitor were subject to the emergency department environment.
- On the children's inpatient unit there was a consultant and a registrar and a foundation programme doctor. A consultant was available on the ward until 5pm from Monday to Friday but some consultants chose to stay until 9pm. This did not meet the national guidance recommendations which suggest there should be a consultant presence until 10pm each day, including weekends.
- Psychiatric liaison services were available seven days a week from 8am to 8pm.

Consent

- All the staff we spoke with had a sound understanding of the need for informed consent to be obtained before providing care or treatment.

- Verbal consent was sought each time staff carried out any examination, observations or provided treatment. This was usually from both the child and their accompanying parent (unless the child was too young to understand).
- Records seen indicated that written consent was obtained prior to surgery or other interventional procedure.
- Staff could describe actions taken when they believed a child or young person lacked capacity and talked about the age ranges where the Mental Health Act (2007) and Mental Capacity Act (2005) were applicable.

Are services for children and young people caring?

Good

We rated caring as Good because:

- Most patients and parents talked positively about the staff. Words such as lovely, funny, sweet, kind, patient, gentle and calm were used to describe them.
- Even when really stretched with a high volume of sick children and low staffing levels, the nurses in the children's emergency department remained very warm and compassionate towards the children and their families.
- Staff on the SCBU received unanimous praise from the parents who we spoke with. They talked about being involved, being encouraged to hold their babies, being given good explanations and being given an opportunity to ask questions.

However:

- Reception staff in the accident and emergency department were not always respectful in their dealings with patients and parents.
- Families on the ward described most staff as very kind, helpful and gentle. This was not universal though and some parents told us that some staff were dismissive and disinterested.

Compassionate care

- We spoke with two parents on the SCBU who told us they were very pleased with the quality of care they and their babies were receiving. They described the staff as supportive, caring and kind.
- In the emergency department paediatric resuscitation bay, we saw a student nurse offer a mother a drink and saw they fetched her a chair.
- We spoke with three parents and children when we made an evening visit to the emergency department. We observed that nursing staff remained kind and gentle towards the children, despite being very busy. Parents said the nurses were gentle and patient with their children.
- We observed reception staff being dismissive of an anxious parent and failing to listen to their valid concerns.
- We observed the reception area for a short period of time and saw parents arrive very concerned about their three-week-old baby. We saw the receptionist did not make eye contact or smile. Reception staff did not advise the parents on the current waiting times or who would see their child. The parents first language did not appear to be English but there was no offer of a translator.
- We spoke with five children and families on Rainbow ward. One parent described the care their child had received and knew the plan of care. They said they had been fully involved in decision making and couldn't fault the doctors. They felt staff were empathetic and ensured that parents were comfortable.
- Another parent on the wards said that the care was "just okay and sometimes inconsistent". They felt this was a domino effect from low staffing levels. This parent described an individual staff member who had gone the extra mile and taken time out to explain something they hadn't understood.
- One parent who had been on the ward several days said, some nurses were kind and good and others are okay. Nobody was horrible but some nurses just weren't that friendly".

- The play leader was described as, “excellent”. They were said to come and change toys regularly and try to give parents of children in Hospital a long time, some time.
- The Rainbow ward information board showed that, for July 2018, the Friends and Family test score was 100% of people responding would recommend the hospital. There had been 21 responses.
- The Child Health Board minutes showed that the score in August 2018 for Rainbow ward was 91.49% with one person saying they were unlikely to recommend the ward. There were 47 responses.

Understanding and involvement of patients and those close to them

- We observed a nurse on the SCBU explain the reasons for admission and the care the baby would receive to a new mother. It was done in a way that ensured the mother understood what was happening and could ask questions. The nurse also showed the mother around the unit.
- We observed a consultant ward round and noted there was a clear plan of care agreed involving the parents and explaining the necessary tests in a way they could understand.
- In the emergency department paediatric resuscitation bay, the registrar leading the care management of the child spoke with the child’s mother, gaining her opinions and the child’s history and explaining what the immediate plan of care was.
- There was a photo board on Rainbow ward that explained who the staff were.
- On Rainbow ward, parents told us they could ask questions and were involved in making decisions about their child’s care.

Emotional support

- There was no play specialist in the children’s emergency department.
- The *Local Risk Report* showed that there was an inadequate psychology service for children with diabetes. The risk control measures reported that a psychology assessment was carried out by specialist nurses who prioritised and referred the child to the next available appointment. The entry said that this may not be local to the patient. The specialist nurses were also utilising school counselling services but this did not meet the need due to a lack of diabetes knowledge.
- There were specialist nurses for children with cystic fibrosis and epilepsy who could provide emotional support to children and young people with these conditions.

Are services for children and young people responsive?

Requires improvement

We rated responsive as Requires Improvement because:

- The resourcing and service for children with mental health needs was insufficient to meet the needs of the child or young person.
- There was not a shared understanding of the flow through the emergency department by operational or senior staff.
- Children were being cared for by adult trained nurses in environments designed for adults – both in the emergency department and in theatres.
- The journey to theatres had not been adapted to be child friendly.
- There were frequent breaches of the four-hour target in the emergency department.
- Referral to treatment times resulted in delayed treatment. Fifteen urgent referrals waited over 13 weeks to be seen.
- There was limited recognition of the needs of children and young people with a learning disability or autism. There were identified link nurses but they had not received any training.
- The bereavement pathways in the emergency department were confused and staff did not have a good understanding of what resources and facilities were available to them.
- There was little consideration of the needs of children aged between 16 and 18 years of age.
- There was poor provision of paediatric mental health advice and assessment.

However:

- A GP was available in the emergency department to review children between 10am and midnight Monday to Saturday.
- The trust had a flagging system for children with learning disabilities so patients arriving in accident and emergency departments would be identifiable.

Service planning and delivery to meet the needs of local people

- Elective and emergency surgery was carried out at Queen Elizabeth the Queen Mother Hospital which reduced the need for travelling to more distant centres. The journey to theatres had not been adapted to be child friendly.
- Mental health services for children and young people were commissioned by the Clinical Commissioning Group from another NHS trust. The delivery of the service to the Queen Elizabeth the Queen Mother Hospital was not adequate to meet the needs of the needs of the local community.
- The onsite Special Care Baby Unit meant that babies who required additional support or observation could remain closer to home.

Access and flow

- The flow of children and their pathway through the emergency department was confused and not well understood by staff. The senior staff told us a completely different pathway to that understood by staff working in the emergency department.
- The senior matron for children's services told us children brought in through the front doors of the emergency department registered at the main desk and were then taken straight through to the children's waiting area for triage by a paediatric nurse. Once triaged they were then seen by an emergency nurse practitioner, an emergency department doctor or a paediatric doctor.
- We were told that any baby under six months or any child under a year between the hours of 11pm and 8am were automatically referred to the paediatric team.
- We spoke with a nine-year-old child and their mother. They had registered with the receptionists and were then placed in the crowded to be seen by 'streaming'. They had been in the adult waiting room for 40 minutes when we spoke with them. The family waiting room was empty at the time.
- Frontline staff had a very mixed view about whether children were seen by the adult streaming nurse or not. We were told it depended how busy they were and that children were sometimes seen by them before being triaged.
- We were told that the streaming nurse did not see children unless they were a senior band five nurse and they decided whether it was appropriate to see children. They sometimes saw all the children but usually sent them through to triage unless they were needing resuscitation. They told us that they had no competence assessment or experience of assessing children.
- There was a GP based in the emergency department and sometimes if the children's emergency service was busy streaming they sent patients there. We were told, "It just depended". The GP was in the department from 10am to midnight Monday to Saturday.
- The streaming nurse (when seeing children) saw everyone in the order they presented to the receptionists. There was no prioritising, no placing children ahead of others and no different assessment process for children.
- The triage nurses were children's nurses who worked in the children's emergency unit and provided care to all the children in the bay as well as providing a triage service. They saw all children and assessed their needs and determined the best place for them to continue the assessment or be treated.
- The families usually waited in the family waiting area although sometimes the adult waiting room was used. The family waiting room was also used for overspill when the unit was too busy to offer a place in the main children's bay. Some children returned to the family waiting area after triage whilst awaiting medical review.
- From triage the children were directed to one of four options, the main children's bay in the emergency department, the Children's Assessment Unit, directly to the ward or home. At weekends and out of hours the Children's Assessment Unit was closed and an advanced nurse

practitioner worked alongside staff in the emergency department. As there was no dedicated space for them to assess and treat patients, this impacted on the flow of patients through the department.

- Children with mental health needs followed the same pathways but sometimes there was support from a healthcare assistant brought from another area or the hospital or the clinical technician in the children's emergency department provided one to one care. If the child showed challenging behaviour, security or the police were called.
- Information provided by the trust showed that in the quarter from July 2018 to September 2018 there were 130 breaches of the four-hour time from booking to treatment.
- The longest time to assessment for the patients who breached was 97 minutes with another at 66 minutes and more assessments in the 50-60-minute range.
- In the morning, we saw a 16-year-old child was kept overnight on a trolley in the children's emergency department, which was usually not staffed after 2am. We spoke with a senior sister about this and were told they were waiting for a medical bed on a medical ward but that there were none available. We asked why they had not been moved to one of the empty cubicles or the teenage bay on the children's ward, so that they could sleep and have their mother with them and were told it was because the medical team didn't cover the children's ward.
- The trust policy on admission of children is unclear about 16-year olds. It does say, children aged 0 to 16 years and 364 days who are admitted to the children's wards under the surgical or other divisions will remain the responsibility of the named adult consultant and will be reviewed daily by the admitting team who will take full responsibility for all interventions and management, but they will be supervised by the consultant of the week who will provide shared care as appropriate and clinically indicated. According to trust policy, there was no reason that this child remained in the emergency department when there were cubicles and an empty teenage bay available.
- We noted that, due to a lack of space, observations were being taken in the family waiting room. Medicine was also administered to children waiting there.
- The Children's Assessment Unit was a two-trolley bay and a single room which was usually managed by an advanced nurse practitioner and a band five nurse. The band five nurse worked from 9am to 9pm and the advanced nurse practitioner from 9am to 10pm. The unit was open from 9am to 9pm Monday to Friday. At weekends the advanced nurse practitioner worked from the children's emergency care area.
- The pathway for the care of a child who died was also confused with different staff telling us different things. The senior matron said the trust followed the guidance of the Kent child death overview panel. There is a statutory obligation to follow this pathway but it does not provide detailed information about the resources and individual hospital response to the family but rather focusses on the administrative requirements and a basic philosophy of care.
- We were told that a consulting room at the back of the emergency department was available and used for the families of a child who had died. Then, if the parents wished the child could be transferred to a local children's hospice for after death care or the parents could use a room on the children's ward as a sitting area. It was also possible to discharge the child to their parents care and they could borrow a cot from the Special Care Baby Unit, if necessary.
- However, staff working in the emergency department suggested the family remained with their child in the paediatric resuscitation bay. This was an unsuitable environment for post-death care as there was no privacy, it was a clinical environment and the adjacent adult bays meant staff were walking in and out frequently. We asked what happened if another sick child needed the paediatric resuscitation bay and were told that the bereaved family and child would be moved into one of the adult bays.
- The current trust waiting list at July 2018 was 1,633 for outpatient appointments and no inpatient waiting list. The backlog was 93 with a suggested time to clear the backlog of one week. The calculated wait was 13 weeks for outpatient appointments.
- Sixty percent of patients were seen within 12 weeks.
- Ninety percent of patents were seen within 24 weeks which was worse than reported the preceding month.
- Fifteen urgent referrals were received in July 2018 with a first outpatient appointment of 13 plus weeks and one waiting between 19-24 weeks.
- The referral to treatment time data contained within the minutes of the Child Health board showed that there had been 69 breaches of the 18-week target for general paediatrics, six for community paediatrics, 55 for community paediatric neuro-disability and 13 for paediatric

cardiology. There had been a total of 143 breaches of the 18-week target where patients were still awaiting an outpatient appointment. There were a further 44 patients where the OPA 'was still ticking' and overall a total of 187 breaches of the target with 17 over 35 weeks and four

- over 52 weeks.
- Compliance with the two-week wait for suspected cancer referrals was 100% compliant in July 2018 but had been lower earlier in the year with 84% in April 2018 and 88.9% in January 2018. The overall numbers for these targets are low and reflect one or two patients who have not been seen within the two weeks.

Meeting people's individual needs

- The trust had arrangements, known to all staff on duty, to meet patients' urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. The Clinical Commissioning Group commissioned a child and adolescent mental health crisis service from another NHS trust. Staff were aware of the phone number of the crisis team but said that the team covered a large geographical area and that sometimes no staff were available to attend to assess and plan care for a child in crisis. The norm was a wait of several hours before anyone could come to the hospital and staff had to manage in the interim.
- Staff and the care systems they followed were insufficiently resourced to enable staff to provide good care to patients in need of additional support.
- A small cohort of staff received training between April and August 2017 in meeting the complex needs of children and young people with mental health disorders. There was no staff training on mental health in children provided within the 12 months prior to this inspection. This meant staff who had joined the trust after August 2017 had not received training in this area.
- The trust did not employ any child mental health specialist staff.
- The poor access to mental health advice and assessment meant that children and young people did not always get the necessary emotional support.
- Staff did not feel competent to manage children and young people with mental health needs. They told us they referred children to the mental health crisis service team and did their best whilst the child was in their care awaiting transfer to a mental health bed. Most of these children were discharged within 24 hours of admission.
- Staff arranged one to one nursing using NHS Professionals. If a registered mental health nurse could not be obtained, then staff used 'Safe Assist'. The chief nurse explained this was a service provided by a third-party and consisted of a group of carers who had undergone trust training in safeguarding and dementia. The carers would not provide any clinical care. However, Safe Assist would not be used in accident and emergency, instead a healthcare assistant would normally be allocated to provide one to one assistance or staff told us they could use security.
- Staff talked to us about an incident were a child with mental health needs absconded from the children's ward. The teenager was not complying with essential, lifesaving medication routines. The trust used an advanced nurse practitioner to sit with the patient but they still ran off the ward. We were told security contained them in the corridor but the child was very violent on return to the ward, throwing furniture and other items. The patient claimed security had tried to hit them. The child was also deemed to lack capacity to make an informed decision about whether to remain on the ward. A referral to the child and adolescent mental health service was rejected. An incident form was submitted over a month ago but there had, at the time of the inspection visit, been no feedback to staff on the ward.
- Staff were unaware of the trust policy on this and felt that they should speak with the safeguarding team and call the police.
- The intercollegiate guidance document *Standards for Children's Surgery* 2013 states that procedures should minimise anxiety for the child including shortest fasting times, allowing children to wear their clothes to theatre, imaginative modes of transport to and from theatre, considering safety and good communication among staff to minimise waiting times.
- At Queen Elizabeth the Queen Mother Hospital this was not happening. Children were being asked to fast for either the morning list or the afternoon list with a set time to begin fasting for each. Children were not encouraged to wear their own clothes to theatre, except for dental lists, but were provided with children's theatre gowns. They often travelled to theatre on a trolley despite being able to walk or being small enough to carry.

- Staff told us that they had no training in caring for children and young people with learning disabilities. They suggested that they, “just picked it up as they went along” and relied on the parents for guidance.
- The trust had a flagging system for children with learning disabilities so patients arriving in accident and emergency departments would be identifiable. Wards flagged new cases to the learning disability practitioner who then added the child to the database.
- Although the trust told us there were communication boxes, sign language facilities, pictorial menus and pictorial pain tools in use, staff were unaware of any communication aids. The learning disability ward champion told us there was a poster displaying Makaton but no staff had received training on this.
- The trust did not have any education provision on site due to the majority of children being admitted for less than five days, However, if a child is admitted longer than five days, the trust encourage the parents to liaise with the child’s school or the trust could refer to Kent health needs education service.
- In the Special Care Baby Unit, staff considered the wider needs of the babies and their families. Cots and incubators had toys such as mobiles and mirrors to stimulate an interest in the world around them and promote development. Parents were encouraged to personalise the cots with small soft toys or blankets.
- While in the resuscitation area looking at equipment a nurse showed us the child bereavement boxes which families were given. These were beautifully decorated boxes with items such as a candle, two teddy bears (one for the family and one to stay with the child) and the contact numbers of support organisations.
- On Rainbow ward there was a noise indicator box that lit up when noise levels became too loud and could impact on children trying to sleep or who found high noise levels challenging.
- The ward was separated into age groups with a bay for young children aged two to five years and a four-bedded bay for teenagers which mean children were accommodated with peers. However, there was no segregation by gender and the teenage bay was mixed sex which had potential to compromise the privacy and dignity of older teenagers.
- Babies under six months were cared for in cubicles to reduce the risk of hospital acquired infections.
- The trust had a policy for the *Management of Adolescent Transitional Care* dated December 2015 and due for review in December 2018. It explained the ‘Ready, Steady, Go’ transition programme which was started when the child was around 11 years of age. At each stage, the child completed a questionnaire to establish what needs to be done for a successful move to adult services. The consultant took responsibility to address the issues raised by the child. There were no eligible children for the programme admitted at the time of our inspection.

Learning from complaints and concerns

- Staff understanding of the complaint process was limited. Senior nursing staff told us that there were very few complaints from children’s services.
- The minutes for the specialist services divisional board for Child Health meeting showed there were four new complaints in June, no new complaints in July and three new complaints in August 2018.
- At 11 September 2018, there were three complaints opened for less than 30 days and two complaints opened between 31 and 60 days. One complaint was open with the Parliamentary and Health Service Ombudsman.
- In August 2018, the Child Health directorate had closed no complaints within the 30-day response time but both complaints closed in this month were closed within the timescale agreed with the patient.
- The specialist services divisional board for Child Health considered complaints and the learning from complaints at each monthly meeting. However, the learning identified did not necessarily address the cause of the complaint nor provide an adequate tool to learn from mistakes.
- In July 2018 the closure performance figures for the trust were 100% compliance with the agreed timescale with the complainant but 20% with the 30-day response time.

- The Child Health board considered complaints and the learning from complaints at each meeting. However, the learning identified did not necessarily address the cause of the complaint nor provide an adequate tool to learn from mistakes.
- One complaint detailed in the September 2018 report of the Child Health board showed that a parent had complained about delays in the emergency department and on Rainbow ward when they took their child with post-operative bleeding and the extent of the bleeding was never assessed by staff. They were not kept informed despite consideration of moving the child to London for further surgery. Eventually, they discharged themselves and went back to the clinic where the surgery had taken place. The complaint was upheld. Actions were recorded within the minutes but the focus was almost entirely on action to remind nursing staff of their responsibilities and did not address failings by the medical staff. The actions stated were vague and did not give timescales or allocated responsibility for dissemination or implementation. One action was that "communication would be improved with parents" but there were no details of how this was to be achieved.
- Another complaint was from the parents of a baby on the Special Care Baby Unit where there was no named consultant, no follow up was arranged and a failure to review medication dosage as the baby grew and a consequent chronic under dosing. The actions to address the concerns were not adequate to ensure there was no recurrence with other babies. The Child Health board minutes showed that there should be development of formal arrangements to ensure there was appropriate consultant cover for long term absence. There was no named person responsible for doing this and no timescale which meant that there was no assurance that it would happen. Similarly, the minutes stated, "upload care plans to EPR". There was no timescale and no person accountable identified for doing this.

Are services for children and young people well-led?

Inadequate

We rated well-led as Inadequate because:

- There was no clear vision for children's services and no oversight of all the children using trust services. The stated vision was not understood by staff.
- The board were receiving false assurance around, for example, incidents and compliance with Sepsis and PEWS policy compliance. Incidents weren't reported so all subsequent data provides an inaccurate overview.
- Governance systems were ineffective. The Child Health board did not have good oversight of the challenges the service faced, the key risks and did not ensure that these risks were mitigated in a timely way. We were told by senior staff, including the executive lead, that the board needed strengthening.
- Leadership of services for children was not clear with no one person who accepted responsibility for all the children passing through trust services. There was no joining of the various areas of the hospital that children accessed to form a single cohesive service that made sure the needs of the children were paramount.
- Insufficient mitigation was put in place where serious risks were identified. There was a lack of timeliness in the responses to significant risk. Responses were reactive rather than proactive, with recording on action plans rather than actions being completed. The use of adult trolleys for babies and toddlers and the lack of security on the children's ward were examples of this.
- Policies and practice guidance was created in response to incidents but was not disseminated effectively. Senior staff told us and action plans showed that new guidance and policies were embedded but the reality was that operational staff were unaware of them.

However:

- There was some positive feedback on local leaders, particularly from the Special Care Baby Unit staff.
- The results for the Workplace Race Equality Standards were broadly in line with the national average of similar trusts.

- There were attempts to engage with the parents and carers of children using trust services.

Vision and strategy for this service

- It was felt by the chief nurse that there wasn't a clear strategy for children and young people's services within the trust. However, the trust leadership team were aware of areas in children and young people's services that required greater visibility and focus and a plan to strengthen the work was already in progress.
- There was a consultation in progress about consolidation of the services and potential changes to where services were delivered from.
- We were told by the chief nurse that there was an objective to increase the voice of children and young people with ideas such as a using social media and a mother talking to the neonatal meetings, but there was no evidence this had been carried through.
- We were told by chief nurse that the care of children and young people was everybody's business, but this was not a vision that was clearly understood or repeated by frontline staff.
- The emergency department lead matron was not included in the development of the business case planning despite being in post sufficient time to have a real understanding of the children's emergency care service.
- The intercollegiate guidance document *Standards for Children's Surgery* 2013 states that there should be a commitment from the executive team and senior staff to the provision of a high-quality children's surgical service. This was not evident from senior staff who did not understand the needs of children undergoing surgery and felt there was no clear strategy in place.

Governance, risk management and quality measurement

- We asked the chief nurse about the three biggest risks facing children's services across the trust. These were identified as;
- Recruitment and retention; it was felt that staff were often attracted to travel to London to work. The trust had used recruitment incentives which included a £500 bonus if a staff member introduced someone and they were employed at the trust.
- Pathway of 16 to 18-year olds; we were told that the trust had taken urgent action with medical team to rectify the pathway but we saw very poor management of a 16 -year-old child admitted via their GP to the emergency department, which suggested the urgent action had not been effective.
- Meeting the needs of children with mental health problems admitted in crisis, some of whom exhibited very challenging behaviour - services for such children are commissioned by the Clinical Commissioning Group with another NHS trust based in London.
- We spoke with a senior nurse in the emergency department who identified the three most serious risks as staffing, 24-hour care of children and caring for children in mental health crisis.
- The divisional risk register's highest risk reported in the Child Health board minutes for month four showed the there was a reported and recognised inability to deliver effective paediatric service and to meet the Royal College of Paediatric and Child Health standards for this service.
- The divisional risk register also highlighted that there were insufficient placements for children with mental health problems.
- These did not appear to be escalated to the corporate risk register and as such, the trust board may not have had sufficient oversight of the seriousness of concerns within children's' services.
- The *Local Risk Report* dated 29 October 2018 did not highlight staffing in the emergency department or on the ward as a significant risk.
- The corporate risk register did show that there were inadequate safeguarding training arrangements trust wide for both adult and child safeguarding.
- There was poor incident reporting, which was acknowledged by some senior staff. The incident reports to the governance meetings and the board were not reflective of the frequency or severity of incident and provided false assurance.
- Vital signs audits were undertaken and showed poor performance, The October 2018 audit showed that the key performance indicator (KPI) of observations being recorded within 15

minutes of arrival was 20% compared to the Royal College of Emergency Medicine standard of 100%. The KPI around repeated observations was also 20% against a target of 100%. During the October audit, from the sample taken 10% had a PEWS score of three but there was no evidence that it was recognised or acted upon.

- The action plan from the September 2018 audit is insufficiently robust to address the continual poor performance. It merely stated what the target performance should be but provides no detail of how this to be achieved nor who is responsible for driving any of the improvements. It shows regular and ongoing identification of a recurring shortfall in practice but no effective leadership or action to make improvements.
- The Child Health patient safety action plan showed that poor PEWS chart completion was identified as an issue by the directorate prior to November 2017. The action plan stated that, "Monthly audits not being consistently carried out on acute wards. Reporting to happen monthly at Divisional Governance meetings. New way of capturing audit implemented from April 2018". The actions to address the concerns were ineffective and had been allowed to continue for at least 12 months.
- The *Local Risk Report* dated 29 October 2018 showed the risk of unauthorised access to Padua ward at William Harvey Hospital had been identified and action was being taken to address this, but the same risk on Rainbow ward did not appear on the report. The senior matron was aware of the risk but there was no recorded action on the plan.
- The data contained within the board meeting minutes was not comprehensive. Data was often not split by hospital site or profession. For example, the workforce key performance overview contained a compliance rate for mandatory training of 91%. However, this provided false assurance to the board, as we saw very poor compliance rates for teams within the service based at different sites. The senior management team could not identify specific hotspots or areas requiring improvement.
- Some of the performance data was only available at directorate level. As the data was not always available at site level, the trust was unable to identify if any of the sites were an outlier. Therefore, risk management and oversight remained limited.

Leadership of service

- The trust had a leadership structure of clinically led teams arranged as seven divisions. Services for children and young people sat within the Women's & Children's directorate.
- There was a clinical director who was a senior doctor supported by a band 8b senior matron for of children's services and an interim operational director.
- Reporting to the senior matron was a band 8a matron who covered the inpatient and outpatient services at both sites. They were based at Queen Elizabeth the Queen Mother Hospital.
- A neonatal matron band 8a was based at William Harvey Hospital, but covered both sites.
- Children attending the emergency department were the responsibility of the emergency department staff whose line management and deployment was via the emergency department. The business case for additional staff in the children's emergency department was made by the head of nursing for urgent and emergency care.
- Concerns were raised about a non-inclusive culture within the emergency department with poor oversight from the previous head of nursing. The current post holder had only been in post two weeks and it was felt they had a more positive attitude.
- Staff told us the lead nurse for urgent and emergency care was based at the William Harvey Hospital but covered both sites. They were said to have not visited the Queen Elizabeth the Queen Mother Hospital site in four months.
- The chief executive office had visited during the previous week.
- The executive lead for children's services was the chief nurse.
- The head of urgent and emergency care attended the children's board which provided the governance leadership for children's services.
- We were told that children's services, "worked in a matrix way" but we remained unclear what this meant in practice. We were also told by the chief nurse that, "the children's board needed strengthening to have a stronger influence".
- Local leadership for children's services was unclear. Leadership of the children's emergency department was by nurses who were not trained children's nurses. There was no specific leadership of children's services in the theatres; children were perceived as simply an add on to

the adult services with very little evidence of leadership driving improvements in the care of children undergoing surgery.

- There was no evidence of leadership for services for children aged between 16 years and 18 years. Despite the chief nurse telling us that the care of children and young people was everybody's business, this was not applied in practice. The needs of young people were secondary to the usual routine of hospital and the preferences of adult medical teams to have their patients on adult wards.
- The 2017 national NHS Staff Survey showed that the trust was performing badly for the key findings related to management. The results had worsened since the 2016 staff survey.
- Generally, staff reported very favourably on the medical leadership of children's services and of the Special Care Baby Unit.
- Staff working on the Special Care Baby Unit reported positively about the leadership of the unit and felt there was a strong team ethos.
- Since our inspection, daily safety huddles have been implemented between senior nursing staff, the chief nurse and deputy chief nurse to discuss the operational risks within the children services.

Culture within the service

- Senior staff told us that that there were no themes around culture and no concerns with bullying in children's services.
- The NHS Staff survey 2017 showed that the trust was in the worst 20% of trusts for the key findings associated with bullying and harassment by other staff and for reporting this.
- Staff perception of the culture was very mixed. Some described regular visits and support from individual leaders while others described themselves as invisible with nobody wanting to listen or engage with how hard direct work with children and families was.
- Amongst staff there was clearly a supportive culture with staff working additional unpaid hours and taking on additional tasks to support their peers.
- On the Special Care Baby Unit, staff described the culture positively and said they felt listened to and supported.

Equalities and Diversity – including Workforce Race Equality Standard

- For the key measure, "In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?" the performance was in line with other trusts.
- 84% of black or minority ethnic staff believed that the organisation provided equal opportunities for career progression or promotion which was in line with other trusts nationally.
- The percentage of black or minority ethnic staff experiencing harassment, bullying or abuse from staff in last 12 months was 36% compared to the trust wide result for all staff of 26%.

Public engagement

- The trust had a parent and carers involvement group that was established as a forum to gain parental views and feedback on information that the service provides for parents and carers of children and young people who access the Child Health services. The aim was to work together with parents and carers to review or amend current information available to parents and carers and develop future information which parents or carers feel would be helpful.

Staff engagement

- The 2017 National NHS Staff Survey showed that the trust was in the lowest (worst) quintile for overall staff engagement when compared to similar trusts.
- Staff satisfaction with the quality of work and care they are able to deliver was rated below the national trust average.
- The survey showed that the trust was in the worst 20% of performing trusts for the key findings about job satisfaction, which included team working, resourcing and motivation.
- Staff received a monthly Child Health newsletter to communicate key updates, celebrate achievements and update on staff moves.

Areas for improvement

Action the hospital MUST take to improve

- The trust must provide suitable accommodation for children and young people with mental health problems.
- The trust must review their booking and triage processes to ensure all staff are clear about the pathway children take through the emergency department and to minimise the time before they are assessed by an appropriately qualified children's nurse.
- The trust must ensure that equipment checks required by trust policies are enacted.
- The trust must ensure the safe management of medicines.
- The trust must ensure that clinicians are aware and follow trust policy and national guidance on the safe management of deteriorating children, testicular torsion and sepsis identification and management.
- The trust must ensure that children wait in the children's waiting area at all times. They must not be exposed to volatile behaviour, inappropriate televisions programmes and unpleasant sights and sounds in the adult waiting area.
- The trust must ensure the views of children and young people are taken into consideration to aid service provision and make sure the care and treatment meets their needs and reflects their preferences.
- The trust must review the care of children aged 16 years to 18 years and ensure that their needs are fully considered.
- The trust must ensure submission of data to national audit programmes to allow benchmarking against other children's services and to drive improvements.
- The trust must ensure that they adhere to a local audit plan and use the results to drive service improvements.
- The trust must carry out a learning needs analysis for nursing staff working with children and young people to assist in identifying what training is necessary and where there are gaps in staff skills and knowledge.
- The trust must ensure that staff are provided with the necessary training and support to ensure they can carry out their work competently.
- The trust must ensure compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections. This to include ensuring there is appropriate isolation facilities in the children's emergency department for children with communicable diseases.
- The trust must review their policy and usual practice on pre-operative fasting for children to ensure it is aligned to the national guidance.
- The trust must ensure that up to date policies and protocols are available to staff.
- The trust must ensure that the needs of children and young people presenting in mental health crisis are considered and met.
- The trust must ensure that there are no breaches of the four-hour admission to treatment target for children attending the emergency department.
- The trust must develop a clear vision for children's services that is recognised and shared by all staff caring for children and young people.
- The trust must ensure that data and information provided to the board is an accurate reflection of the services being provided to avoid the risk of false assurance.
- The trust must undertake an assurance review of their children's service to identify gaps in their assurance and governance processes.
- The trust must ensure that there is clear, accountable leadership of services for all children from birth to 18 years (and beyond 18 years for looked after children and children in need).

Action the hospital SHOULD take to improve

- The trust should provide staff with training in the care of children and young people with autism and learning disabilities.
- The trust should ensure that the pathway for providing care when a child dies is known and understood by all staff likely to be affected.
- The trust should provide all staff including senior leaders with training in equality and diversity.
- The trust should consider providing customer service training for reception staff in the emergency department.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of Disease, Disorder and Injury Surgical procedures Diagnostic and screening procedures	Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	**Regulation**
Treatment of Disease, Disorder and Injury Surgical procedures Diagnostic and screening procedures	Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	**Regulation**
Treatment of Disease, Disorder and Injury Surgical procedures Diagnostic and screening procedures	Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	**Regulation**
Treatment of Disease, Disorder and Injury Surgical procedures Diagnostic and screening procedures	Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	**Regulation**
Treatment of Disease, Disorder and Injury Surgical procedures Diagnostic and screening procedures	Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of Disease, Disorder and Injury. Surgical procedures. Diagnostic and screening procedures.	We issued an urgent Notice of Decision under section 31 Health and Social Care Act 2008 to impose conditions on the provider's registration.