East Kent Hospitals University NHS Foundation Trust

William Harvey 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 the William Harvey 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 William Harvey 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.

- Staff do not recognise concerns, incidents or near misses. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was little evidence of learning from events or action taken to improve safety.
- Frequent staff shortages increased risks to children and young people who used the services.
- There were inconsistent infection, prevention and control practice.
- Medical records were not stored securely.
- There was poor oversight of medicines management.
- Staff did not have assurance all equipment was clean, fit for purpose and ready for patient use.
- Staff did not assess, monitor or manage risks to people who use the services. Opportunities to prevent or minimise harm were missed.

The services for children and young people were not effective.

- Clinical audits were not being completed within the scheduled timeframes which meant there were no current performance indicators for the trust against national standards.
- There was confusion amongst staff on how to access policies and guidelines.
- There were gaps in the seven-day service provision that meant children had to be treated in adult environments by adult staff.
- The compliance rates for appraisals were worse than the trust target.
- Staff had limited training in the management of children with mental health needs.
- Ward rounds were not multidisciplinary which was a missed opportunity to plan and co-ordinate patient care and treatment.
- Fasting times before surgery did not follow current best practice and put the needs of the service before the needs of the children.
- There was no recognition of the psychological needs of children and young people in the operating theatre environment.
- Pain thresholds were not assessed in a timely manner.

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

- People were not always treated with kindness or respect.
- Staff did not see people's privacy and dignity as a priority.
- There was an inadequate psychology service for children with diabetes.
- There was poor provision of paediatric mental health advice and assessment.

The services for children and young people were not responsive.

- Minimal effort was made to understand the needs of the local population. The services were planned and delivered without consideration of people's needs.
- The provision of service to meet the needs of children with mental health or learning disabilities was insufficient.
- The facilities and premises used do not meet people's needs.
- Children and their families were frequently and consistently unable to access services in a timely way for an initial assessment, diagnosis or treatment. They experienced unacceptable waits for some services.
- Staff did not understand the pathway for children within the emergency department.
- There was little evidence to show concerns and complaints led to improvements in the quality of care.
- Lack of children services 24 hours a day led to children being cared for in adult designated areas within the emergency department.

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

- The services did not have a clear vision or strategy.

- Continuous improvement, and learning from when things go wrong was not evident across all areas.
- Governance and risk management processes were ineffective and provided false assurance to the board.
- Significant issues that threaten the delivery of safe and effective care were not identified or adequate action to manage them was not always taken.
- There was little evidence of innovation or service development. There was minimal evidence of learning and reflective practice and the impact of service changes on the quality of care is not understood.
- 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:

- Staff interacted well with babies and used different methods of distraction to keep them calm.
- Children and young people services did consistently well in the friends and family test.
- 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.
- The trust had a flagging system for children with learning disabilities so patients arriving in accident and emergency departments would be identifiable.
- Staff had a sound understanding of the need for informed consent to be obtained before providing care or treatment.
- There was good teamwork amongst staff and staff strived to support their peers.

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, 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 19 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).

In addition, 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.

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	Staff did not always report incidents and when they did the investigation was insufficient. There were frequent staff shortages which increased the risk of harm to children. There was poor oversight of medicines

	management and infection control. Staff missed opportunities to identify deteriorating patients. There were minimal performance indicators for the trust to demonstrate their performance against national standards. Staff did not have sufficient training to enable them to provide safe care for children with mental health conditions or learning disabilities. The service did not always provide evidence based care. The dignity and privacy of children was not always prioritised. The services were planned and delivered without consideration of people's needs. Governance and risk management processes were ineffective and where risks were identified, inadequate action was taken.

William Harvey Hospital

Detailed findings

Inadequate

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Background to William Harvey 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.

At Kent and Canterbury Hospital, Canterbury, there is a Children's Assessment Centre, where children have outpatient appointments or day surgery. Unwell children can be referred by a doctor to the centre for observation and assessment. The centre also houses the Mary Sheridan Centre for children with special educational needs, physical disabilities and a range of neuro-developmental conditions including epilepsy and autism. 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 9:00am and 4:00pm 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 trust has had four Care Quality Commission inspections since 2014. Following the 2014 inspection, the commission put the trust into 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 put 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.

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 raised directly with the commission.

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 as a result of the public, or members of staff, contacting us and information supplied by trust representatives.

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 William Harvey Hospital on the 24 and 25 October 2018. The inspection visits were unannounced and included time spent in the hospital during the night shift.

While at the hospital we spoke with 14 staff and we spoke with four parents or carers to seek their views on the care they received. We reviewed the individual patient records of 15 children. We used direct observation and staffing rotas to confirm staffing levels in all of the 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 William Harvey 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, Queen Elizabeth The Queen Mother Hospital in Margate and Kent and Canterbury Hospital in Canterbury. 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 William Harvey Hospital is an acute hospital. It has a total of 450 beds and provides an extensive range of inpatient, outpatient and elective and emergency services to patients in the greater Ashford area and specialist services to patients across East Kent. It has a postgraduate teaching centre that works in coordination with the local university.

The William Harvey 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

The services for children and young people at the William Harvey 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 the William Harvey Hospital (WHH) has 28 beds for children and young people between the ages of 0 and 16 years. All registered nurses employed within the acute children's service hold a children's nurse qualification. There are also band 4 associate nurse practitioners and band 2 and 3 health care assistants who practice within a skill based competency matrix.

Padua is the children's ward at WHH and provides cares for both medical and surgical patients. The ward consists of 28 inpatient beds for children who need to stay in hospital overnight for treatment, or to recover from surgery.

The day surgery unit operates three times a week for dental, urology and ear, nose and throat procedures. There was a maximum of six children per scheduled list. Children in the day surgery unit were cared for by trained children's nurses from Padua ward.

Children attended main theatres for emergency trauma and orthopaedic, ear, nose and throat and oral and maxillofacial surgery. Main theatres had a separate recovery area for children.

Padua ward has a co-located Children Assessment Unit which opens five days a week between the hours of 9am and 9pm. The four-bedded unit 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, so as to bypass the accident and emergency department, where there was usually a longer wait.

Within the children's ward there was a paediatric outpatient department which held a number of clinics every week to see paediatric referrals and children discharged from hospital requiring follow-up.

The level 3 neonatal intensive care unit consists of 25 cots including seven intensive care cots, eight high dependency cots and eight Special Care Baby Unit cots. It provides intensive care for new born babies from across the region. Children aged 16 to 19 years requiring intensive care support are cared for in the hospital's adult intensive care unit. Paediatric intensive care is provided by a London tertiary retrieval service.

In the emergency department, there is a separate area for children which has a waiting area, three designated child treatment cubicles, a designated child resuscitation bay and one triage room. Children

under the age of six months, after registering in the emergency department, are sent directly to the paediatric ward.

The acute children and young people's service also employ a diabetic paediatric nursing and dietetic team, cystic fibrosis clinical nurse specialist and a paediatric haemophilia nurse. Some sub-specialities such as oncology and cystic fibrosis are delivered with shared care from London tertiary hospitals.

Summary of findings

We rated this service as Inadequate because:

- Incidents were not always reported and there was not a timely or sufficient investigation when incidents were reported.
- There was insufficient resourcing, staff training and consideration of the needs of children and young people with mental health problems and learning disabilities.
- There were inconsistent infection, prevention and control practice.
- The recognition and initial response to deteriorating children was inconsistent and the tools were not properly utilised.
- There was poor medicines management.
- The nursing and medical staffing levels were not in line with the recommendations of national guidance.
- The service did not always provide care in line with best practice.
- There was limited assessment of the quality of care through participation in national and local audit programmes.
- There was limited learning from complaints, comments and incidents. Dissemination of learning was not used as a tool to foster improvements in the quality of care.
- 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 insufficient mitigation when risks were identified and steps to maintain safety were not introduced in a timely way.

However:

- Children and young people services did consistently well in the friends and family test.
- The trust had a flagging system for children with learning disabilities so patients arriving in accident and emergency departments would be identifiable.
- Child safeguarding training within the directorate met the requirements of the intercollegiate guidance.
- Staff interacted well with babies and used different methods of distraction to keep them calm.
- All the staff we spoke with had a sound understanding of the need for informed consent to be obtained before providing care or treatment.
- There was good teamwork amongst staff and staff strived to support their peers.

Are services for children and young people safe?

Inadequate

We rated safe as inadequate because:

- The service was under reporting incidents which meant it missed opportunities to investigate and learn from incidents to reduce the risk of recurrence. There was poor compliance to investigating incidents within the set timeframe and disseminating learning from incidents was not embedded through the directorate.
- Inconsistent infection, prevention and control practice left children and young people at risk of cross infection of communicable diseases.
- Staff did not have assurance all equipment was clean, fit for purpose and ready for patient use.
- Staff did not have assurance medication was safe to administer, as room and drug fridge temperatures were not monitored consistently. There was poor oversight of controlled drugs.

- Medical records were not stored securely.
- Patient risks were not always appropriately identified and acted upon with clear systems to manage a deteriorating patient. This included mental health risks as well as physical.
- The service did not always have enough staff with the right qualifications, skills, training and experience to keep children safe and to provide the right care and treatment.
- The approach to assessing and managing day-to-day risks to people who use services is sometimes focused on clinical risks and does not take a holistic view of people's needs.
- Only 69% of staff had completed hospital life support mandatory training.
- Current flow mechanisms had resulted in delayed triage and treatment for children rather than shortening time between booking and treatment.

However:

- 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.
- 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.
- Staff compliance to mandatory training was good with compliance for eight out of nine modules better or similar to the trust target of 85%.

Incidents

- All staff within the division told us they completed incident reports via an electronic reporting system when staffing levels were unsafe. However, only five staffing level incidents were reported between June and September 2018 at the William Harvey Hospital. These low numbers suggest staff did not always report low staffing levels.
- 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. Although, one member of staff felt this had improved recently and received an email from the manager with feedback from an incident.
- Ward staff did not always recognise incidents which required reporting. We saw the drug fridge and room temperature had been out of range for two consecutive days prior to the inspection but this had not been reported. We also saw errors within the controlled drug logbook which had not been reported. We escalated our concerns to ward management who confirmed they would not think to complete incident reports for these situations but recognised they probably should.
- Staff acknowledged the perinatal maternal mortality and morbidity meetings were not effective. These meetings were held monthly and were attended by medical staff only. Although, there was poor nursing input into these meetings, feedback from these meetings was shared with the nursing teams.
- Between April and September 2018, there were 77 incidents involving children seen by other divisions. Only 23 of the 77 incidents reported trust wide related to the William Harvey Hospital. Nine percent were graded as moderate harm, 43% as low harm and 48% as no harm. The three most common categories of incidents reported were care or treatment, communication and safeguarding. 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.
- Between April and September 2018, there were 311 incidents reported within the Child Health division relating to children under 18 years old, of these 147 were reported by the William Harvey Hospital. Seventy-seven percent of these incidents were graded as no harm and 23% as low harm. However, senior management were unable to discuss any themes from these incidents. This demonstrated poor oversight of incidents within the Child Health division.
- There was poor compliance with the six-week timescale for investigation of incidents. Between July 2017 and July 2018, the best performance against the six-week timescale was in February 2018, when 35% of incidents were investigated within the timescale. This meant the trust may

have missed opportunities to learn from incidents. The minutes for the specialist services divisional board for Child Health meeting in September 2018, did not show poor compliance with incident investigation as a concern that needed addressing. This demonstrated a lack of awareness of the risks within the division.

- There were no never events in this service between October 2017 and September 2018. A never event is a serious incident that is wholly preventable as guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all providers.
- At our last inspection in 2016, the trust was in the process of developing a system whereby incidents involving children seen by other divisions were notified to the Child Health Governance team. At this inspection, this system was in place.
- The minutes for the specialist services divisional board for Child Health meeting in September 2018 showed there were two serious incidents open for investigation. Serious incidents are events in health care where the potential for learning or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to take appropriate action in response. One serious incident was a joint investigation with obstetrics and one was a methicillin-resistant staphylococcus aureus colonisation in the Neonatal Intensive Care Unit at William Harvey Hospital.
- Between April and September 2018, there were a total of 388 incidents relating to children and young people. This meant on average 65 incidents are reported a month trust wide.
- The chief nurse reported that the trust was strengthening learning from incidents through regular meetings such as care group meetings, team meetings, matron meetings and specialist nurse's meetings with the chief nurse.
- Incident reporting was actively encouraged in the Neonatal Intensive Care Unit. The unit management team shared lessons learnt from incidents with the rest of the team.

Cleanliness, infection control and hygiene

- All children's areas had personal protective equipment readily available, this included gloves and aprons. However, we witnessed a member of the housekeeping team walking between different areas of the ward wearing gloves and an apron, which were not changed between tasks. Also, a healthcare assistant in the accident and emergency department cleaned equipment without using personal protective equipment. This could increase the risk of spreading germs.
- During a consultant ward round, we witnessed staff using a stethoscope (a medical device used for listening to the internal sounds of a human body) on babies, however the stethoscope was not cleaned between patients. This could lead to the spread of germs between patients.
- Ward staff did not have assurance equipment was clean and ready to use. Staff had access to a ward checks folder which contained guidance for daily, weekly and monthly cleaning. We saw only two days in October, three days in September and one day in August 2018 were completed.
- Stickers to indicate equipment was clean and ready for use were used inconsistently. In the accident and emergency department, some equipment had dated 'I am clean' stickers. However, we noted one monitor had a sticker dated 12 June 2018. This did not provide assurance equipment was cleaned before patient use.
- The paediatric resuscitation trolley in the accident and emergency department was damaged and felt sticky to touch which indicated it had not been cleaned.
- All staff were bare below the elbows during our inspection. Results for the August 2018 bare below the elbows audit showed 100% compliance for Padua ward.
- During our inspection, all but one staff member cleaned their hands between patients and before and after clinical tasks. Results for the August 2018 hand hygiene audit showed 96% compliance for Padua ward. All staff were informed at the time of the audit of the need for improvement.
- The Specialist Services Divisional Board for Child Health Report dated September 2018 showed there were no reported cases of either clostridium difficile or methicillin resistant staphylococcus aureus bacteraemias.
- The trust had worked closely with external stakeholders in response to an outbreak and colonisation of pseudomonas on the Neonatal Intensive Care Unit at the William Harvey Hospital. Pseudomonas is a bacterium found widely in the environment, such as in soil, water, and plants. The trust had taken appropriate action including screening all babies across the trust, segregating those babies affected and closing the unit to further admissions. There was early

identification of change to practice which involved the use of bottled water instead of tap water to wash babies. At the time of our inspection, the unit was closed to new admissions and there were daily meetings with Public Health England.

- Results for the infection prevention and control audit in August 2018 showed 100% compliance for bare below the elbows and 99% compliance for hand hygiene in the Neonatal Intensive Care Unit.
- Staff maintained the cleanliness and tidiness of the blood gas room on the Neonatal Intensive Care Unit. There were no blood splashes present which demonstrated staff cleaned the surfaces effectively to prevent the spread of blood borne viruses.

Environment and equipment

- Entry to all children's ward areas was secure. Staff granted visitor access to the ward areas via an intercom with CCTV facilities during the day and at night. This ensured unauthorised people did not enter the ward areas.
- Exit from all children's ward areas was not secure as the release button was low down so easily accessible for children. The senior matron was aware of this and said a project to make the exits secure was being introduced at William Harvey Hospital.
- The treatment room in Padua ward was propped open with a clinical waste bin, despite a sign on the door stating, "At no time is this door to be kept open".
- Both sluices in Padua ward were unlocked and we found both commode chairs were dirty.
- We checked six storerooms which had 'fire door keep locked' signs on them. We found all six were unlocked.
- Five used AAA batteries were left on the nursing station during our time on the ward. This posed a risk of children taking the batteries.
- Staff in the accident and emergency paediatric department did not have assurance the resuscitation equipment was fit for purpose and ready to use. The last check recorded was 7 July 2017. There were photographs to demonstrate what each drawer should contain, however the resuscitation trolley we reviewed did not look like this. The last resuscitation trolley audit was completed in June 2018.
- Ward staff did not have assurance the paediatric resuscitation equipment was fit for purpose and ready to use. Only 58% of daily checks for the paediatric resuscitation trolley on Padau ward had been completed. Only 75% of the weekly checks had been completed. We escalated this to the ward manager who told us a new ward diary which will encompass all checks will be implemented by 1 November 2018. She hoped this would improve compliance and oversight of the checks.
- Staff did not have assurance that expressed breastmilk was safe to give to babies. There was no check of the fridge temperature where breast milk was stored. We escalated this to ward management who replaced the old thermometer with a digital thermometer and attached the check sheet to the fridge door to encourage staff to complete it.
- Housekeeping staff took responsibility for recording and checking the parents own fridge which contained food and drink. We saw completed daily checks for October 2018. However, the recorded temperature reflected the fridge setting of 3 degrees rather than the current fridge temperature. There was no thermometer to enable fridge temperature reading.
- Entry to the parents own fridge and the breastmilk fridge were kept open, as were the fridges. Staff explained this was to allow easy access for parents. However, this access should be restricted to prevent milk being tampered with.
- The children's emergency department was closed after 2am. This meant children shared waiting areas with adults in the main emergency department and there was no separation between children and adult patients. There were no facilities available for the distraction of the distressed child in line with the *Royal College of Emergency Medicine: Emergency Department Care* (2017) quality standard 43. This concern was raised at our trust inspection in May 2018.
- 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 small bay with three 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.

- 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 the William Harvey Hospital did not meet this standard. There was no physical separation of the recovery area for children. Curtains were used to provide a degree of visual separation however children could hear adult patients calling out and other unfamiliar and frightening sounds. Children were taken between theatre and recovery along a route that was used by adult patients and staff. It was busy and could have been frightening to a child.
- Staff segregated waste appropriately. We checked four bins on Padua ward and found correct disposal of waste.
- Day surgery staff had assurance the paediatric resuscitation equipment was fit for purpose and ready to use. Staff told us this equipment was checked twice a day and we saw evidence to show daily checks were completed 100% of the time.
- Staff in main theatres had assurance the paediatric resuscitation equipment was fit for purpose and ready to use. The trolley had tamperproof seals and records showed staff completed weekly checks.
- Equipment was maintained and serviced which ensured it was safe to use and fit for purpose. We checked six pieces of equipment on Padua ward and found they had all been serviced within the last 12 months. The due date of the next service was clearly marked on each piece of equipment. Only some equipment had 'I am clean' stickers on them. This meant staff did not have assurance the equipment was ready for patient use.
- Ward staff reported having enough equipment to undertake their roles. All staff received medical device training at induction and received updates when equipment changed for example we saw staff undertake training for new cots on Padua ward during our inspection. Ward management kept a database to track individual staff compliance to equipment training and competence.
- Ward staff knew how to report faulty equipment and reported the electronics and medical engineering department were quick to respond to their requests.
- Piped oxygen and suctioning at bed spaces was readily available and ready for use. We checked five bed spaces and found this equipment was connected and in working order. This meant there would be no delay in staff using this equipment if required during emergency or planned care.
- Padua ward was very hot, especially in the side rooms. Staff told us this had been caused by the automatic turning on of the hospitals heating system. Parents and children had been provided with fans and we saw staff escalate the parent complaints about the heating to estates who visited the ward during the inspection to rectify the problem.
- The Neonatal Intensive Care Unit was clean and tidy. There was adequate storage for incubators but staff told us this was due for refurbishment. The parent breast feeding room had been refurbished to a very high standard.
- Expressed breast milk was stored in clean and tidy fridges and freezers in the Neonatal Intensive Care Unit. All bottles were labelled and dated. Donor breastmilk was stored in blue topped bottles and clearly marked "Do not use without consultant consent" which helped to clearly identify the donor breast milk from parent breast milk. Staff completed daily fridge and freezer temperature checks which ensured the breast milk was kept at the correct temperature and safe to use.

Medicines

- Ward staff did not have assurance medicines were safe to administer. Only 52% of room and drug fridge temperatures were completed for October. When the temperature had been out of expected range there were no actions recorded. We escalated this to the ward manager who reported estates would be called in the first instance and mitigation such as fans would be in place until the issue was resolved. The temperature had been out of range for two consecutive days prior to the inspection, however the ward manager confirmed no action had been taken.
- Staff did not administer medicines in line with NMC standards for medicines. Two of the three children reviewed during ward round did not have any identity bands in place. Staff could not clearly identify the patient before administering medication. We escalated this to a staff nurse

who reported a wristband check was part of the morning routine but she had not had the necessary time to complete her checks for that morning.

- In May 2018, there was an incident relating to a baby having a wristband that belonged to another baby. Actions identified by the trust in response to this incident included that all staff were to check identity wristbands at the start of each shift, and two nurses to check wristbands when being applied to a baby. This practice had not been embedded within the ward and could lead to medicine administration errors.
- There was poor oversight of controlled drugs. Only 63% of daily checks were completed in September 2018 and only 60% of daily checks were completed in October 2018. This meant there would be a delay in identifying any incorrect stock levels. We escalated this to the ward pharmacist who reported quarterly controlled drug audits were undertaken.
- We reviewed the July 2018 controlled drug audit for Padua ward. It showed that stock levels checks were not completed on some occasions for 48 to 72 hours. Actions identified in response to this included for the ward manager to investigate any trends. However, this had not been done as non-compliance with daily checks were still occurring.
- Staff in the paediatric accident and emergency department did not have assurance medicines were safe to administer. There were three days in September 2018 and two days in August 2018 where the room temperature was not recorded. All room temperatures recorded were outside of the expected range but there was no evidence of any action taken. There were five days in September 2018 and three days in August 2018 when the fridge temperature was not recorded. There were two days in August 2018 where the temperature of the drug fridge was outside of the expected range but there was no evidence of any action taken.
- All medicines in the paediatric accident and emergency department were in date and separated according to their preparation such as suspension, tablets and intravenous fluids. However, four out of five opened bottles of liquid medicines did not have the date of their opening labelled on them. This meant staff did not know if they were still safe to administer.
- The resuscitation trolley in the paediatric accident and emergency department was unlocked. This posed a risk an unauthorised person could access and tamper with the medicines.
- Thirty-two medicine incidents were reported between April and September 2018 within the Child Health directorate at the William Harvey Hospital. Of these, 59% were administration errors, 6% were dispensing errors and 34% were prescribing errors. There were no incidents relating to incorrect controlled drug stock levels or out of range room and fridge temperatures.
- Controlled drugs on the Neonatal Intensive Care Unit were stored correctly and staff checked the stock levels daily without omission.
- Up to date copies of the British National Formulary for Children were available on Padua ward.
- During ward rounds, the consultant and medical team reviewed the medicine charts for each child which included a discussion about its suitability, administration route and duration of antibiotics.
- Medicines on Padua ward were secure and stored correctly. There was keypad entry to the medicine room which restricted access to this area. All medicines were locked within cupboards including controlled drugs. Controlled drugs are prescription medicines which are controlled under the misuse of drugs legislation. The nurse in charge kept the keys for the controlled drug cupboard on their person.
- All ward medicines were in date and separated according to their preparation such as suspension, tablets and intravenous fluids. Opened bottles of liquid medicines had the date of their opening clearly labelled on them.
- The deputy director of pharmacy told us the standard of practice for the controlled drug audit was reviewed in September 2018 to strengthen learning from audits. Following our concerns at inspection, all wards within Child Health would be inspected in November 2018. A revised audit form now captured feedback to the ward manager and agreed actions within a set timeframe.
- Ward staff managed patients' own medicines well. There were clear audit trails on when patients had brought their own controlled medicines to hospital and when this was given back to their parent/s.
- Padua ward had an assigned pharmacist each morning with cover provided by other departments if they were on leave. Outside of these hours, the trust pharmacy provided advice during office hours and out of hours there was an on-call pharmacist.

- Staff kept clear and accurate records of administered controlled drugs within the controlled drug logbook in the paediatric accident and emergency department. The last quarterly pharmacy controlled drug audit took place in July 2018, with no actions noted.
- The paediatric accident and emergency department kept a small amount of stock medication for in hospital prescriptions. FP10s were securely stored and their use monitored. The FP10 is a prescription that can be issued by a GP, nurse, pharmacist prescriber, supplementary prescriber or a hospital doctor in England.
- 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 2019 but no recorded updates relating to this.
- We reviewed the June 2018 controlled drug audit for the Neonatal Intensive Care Unit. It showed overall a good standard for the management of controlled drugs. The November 2018 audit showed three areas of improvement with agreed action plans, this included missing a second witness signature, crossing out errors and the transfer of medicines from an old register to a new register.

Records

- On Padua ward, individual patient records were kept in trolleys in the corridor. The trolleys were not locked and there was a risk of unauthorised access of patient records.
- We saw two microbiology test results left on the notes trolley and one discharge letter (containing full patient personal and medical details) left on the unattended nursing station.
- We saw four pages of medical records for one patient filed in another patient's notes. This was escalated to the nurse in charge who took immediate corrective action.
- The October 2018 *Paediatric Early Warning Score (PEWS) Report* for Padua Ward showed that compliance with completion of PEWS charts was inconsistent. All children had a PEWS chart in place that was suitable for their age group, their personal details were legible and the time for each observation was recorded. However, there were poor results for date of observation (4%), blood pressure recorded prior to discharge (73%), first set of observations included a pain score (58%), first set of observations included a blood pressure (62%) and full child's details recorded (69%). The trust target was 95% for all areas.
- 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. However, we reviewed the records for two children in main theatres and found these to be incomplete. One child did not have any pre-assessment recorded. The anaesthetist explained he kept notes of the pre-assessment on the surgery list then transcribed this into the records using his notes. We reviewed the transcribed pre-assessment record and found this did not contain all of the details discussed at pre-assessment. This meant notes were not contemporaneous. One pre-assessment record stated, "fit and well". This did not reflect a comprehensive risk assessment.
- On Padua ward, we reviewed three sets of individual patient records. All notes were comprehensive with clear plans recorded following review by a consultant or registrar.
- The August 2018 *Paediatric Early Warning Score Report* for the Children's Assessment Unit showed that compliance with completion of PEWS charts was good. All children had a PEWS chart in place that was suitable for their age group, their personal details were fully recorded and legible and every observation was legible. However, the action plan for September 2018 suggested compliance with six of the metrics audited had declined.
- On Padua ward, we reviewed four medication administration charts and found these to be completed to a high standard. All children had their allergy status recorded, all prescriptions were legible and were signed and dated, as were administrations.
- On Channel Day Surgery Unit, we reviewed six sets of individual patient records and saw that all entries were completed including patient allergies highlighted in red pen.

- In the paediatric accident and emergency department, we reviewed four PEWS charts and saw they were complete, included evidence of appropriate escalation and the scores were calculated correctly.
- The medical records on the neonatal intensive care unit were completed in line with national professional guidance. We reviewed one set 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 the Neonatal Intensive Care Unit, we reviewed five medication administration charts and found these to be completed to a reasonable standard. All prescriptions were legible and were signed and dated. All personal details were completed and changes to prescriptions were clearly documented. However, one out of five babies did not have their allergy status recorded. We found two incidences where only one signature was recorded for medication requiring counter signature.

Safeguarding

- Safeguarding was everyone's business within the children's services. On ward round, the consultant asked parents about their social history including if there were other children in the household and how they would manage upon the child's discharge.
- Staff knew how to escalate concerns regarding child sexual exploitation and received training as part of their yearly safeguarding children training.
- All incidents involving children under 18 years of age were seen by the named nurse for child safeguarding.
- There was a Safeguarding Children team who provided both clinical and operational leadership for safeguarding children within the organisation. This team consisted of two named doctors, a designated doctor for child safeguarding, a named nurse, three other nurses, a lead midwife and three administrative staff. The team sat within Child Health in the specialist division.
- 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.
- The emergency department had a child protection information sharing system embedded in their screening tool. This is a national alert system to help prevent child abuse. Children could not be discharged until the screening tool was completed.
- The specialist services divisional nurse chaired the bi-monthly safeguarding children committee. This meeting was attended by the head of safeguarding children, the chief nurse, a representative from each division and the clinical commissioning groups. At this meeting, the attendees reviewed progress of actions identified from serious case reviews and the data which is necessary for statutory reporting such as female genital mutilation.
- The head of safeguarding also attended the Children's Services Improvement and Assurance board and reported on safeguarding training compliance alongside the above issues.
- 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, *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 *Safeguarding Supervision* policy 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. In 2018, 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 safeguarding team provided advice and expertise to other staff at the trust through the operation of a duty system, Monday to Friday 9am to 5pm. This meant both 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 trust had a policy within the Women's Health directorate which had been updated and which identified the care pathways for female genital mutilation Additionally, the guidance was updated this year within the current *Safeguarding Children* policy.
- The National Child Protection Information Sharing (CP-IS) project was implemented at the trust in a phased process commencing in January 2018. Staff in unscheduled settings such as the emergency department and children's wards were now able to access the system using their smart card. 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.
- The *Local Risk Report* dated 29 October 2018 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 7 safeguarding advisors had been recruited and were due to start in January 2019.
- The trust's *Safeguarding Children Team Action Plan* for 2017 to 2018 showed that most actions were complete or on track for completion within the timescales set.
- 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. The chief nurse for the trust sat on the Kent & Medway safeguarding children's board.
- The Safeguarding Children team annual report for 2017 to 2018, showed trust wide compliance rates for safeguarding children training were 67% for level 2, 61% for level 3 and 75% for level 4. This was significantly below the trust target of 85%.
- 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. However, staff had a limited knowledge on their responsibility to report female genital mutilation. All staff received this training as part of their corporate induction but stated this was not included in their yearly children safeguarding training.
- On the Neonatal Intensive Care Unit, the safeguarding team joined the ward round once a week to discuss key issues and safeguarding concerns on the unit.
- Data from the trust showed safeguarding children link nurses on the neonatal intensive care unit attended additional training for their roles. Staff had attended four link nurse training days in 2018 so far.

Mandatory training

- Staff completed nine mandatory training modules yearly. The trust set a target of 85% for completion of mandatory training. Trust data showed compliance with mandatory training for the Child Health directorate and Emergency Medicine as follows:
- Hospital life support 69%
- Information governance 83%
- Fire safety 86%
- Equality and diversity 91%
- Moving and handling 91%
- Health and safety awareness 91%
- Infection prevention and control 93%
- Safeguarding children level 2 96%
- Safeguarding children level 3 82%
- Compliance with 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.

- 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

- All paediatric areas used a paediatric early warning score system for the monitoring of vital signs in children, to highlight early signs of deterioration in the child's condition. There were different early warning score forms used depending on the child's age.
- The trust had ratified the guidelines for the *Management of Sepsis in Children* in August 2018. These guidelines were not followed.
- We reviewed four PEWS charts on Padua ward and saw evidence staff were not always adhering to the Royal College of Nursing guidance, *Standards for assessing, measuring and monitoring vital signs in infants, children and young people* (2016). For example, in one PEWS chart we saw the child had scored three, therefore should have had half hourly observations recorded, instead the child had hourly observations recorded. Therefore, staff might not have recognised deteriorating children as quickly as they could have.
- The October 2018 *Paediatric Early Warning Score report* for Padua ward showed 92% of all six early warning triggers had been completed in the children's first set of observations. No children with a score of two or higher for their first set of observations had a documented escalation plan. A local action plan to improve staff completion of escalation plans included measures such as spot checks, direct feedback to staff and discussion at handover and team meetings.
- The October 2018 *Paediatric Early Warning Score report* for the paediatric emergency department at the William Harvey Hospital showed 100% compliance to the Royal College of Emergency Medicine national standard in four out of eight metrics. There was poor compliance with observations taken within 15 minutes of arrival (20%) and repeated observations within an hour (30%).
- Data from the trust received after the inspection, showed that between 8 October and 4 November 2018, 591 paediatric patients attended the paediatric emergency department. Seventy-two percent of paediatric patients were screened for sepsis, and nine patients had red flags indicating possible sepsis. Three were given antibiotics within one hour of diagnosis demonstrating a compliance of only 33%. The trust planned to schedule a meeting between the sepsis lead and the emergency department paediatric lead to discuss improvements and to retrospectively audit records for April to October 2018 to assess the quality of care delivered. In response to our concerns, the trust planned to assess the competence and knowledge of all staff undertaking observations and stated staff would be given dedicated time to attend further training.
- During ward rounds, the consultant and medical team reviewed the PEWS charts of each child to ensure that if required, correct escalation had happened. The team also discussed sepsis screening and subsequent test results.
- Upon discharge, staff informed the parents of signs and symptoms to look for to detect if their child is becoming unwell and what to do in this instance, such as returning to hospital.
- The August 2018 *Paediatric Early Warning Score report* for the Children's Assessment Unit showed 98% of all six early warning triggers had been completed in the children's first set of observations. All children with a score of two or higher for their first set of observations had an escalation plan completed and followed. The September 2018 local action plan to improve recording of early warning triggers included spot checks, immediate staff feedback and discussion at advanced nurse practitioner meetings.
- In the emergency department and on Padua ward we found photocopied PEWS charts in use which did not provide the visual trigger of a coloured score area. Since the inspection, the trust reported all photocopied PEWS charts have been removed from the emergency departments.
- 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 completed in September 2017.
- 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 it required some formatting before it was made available. The policy that was shared with the Commission was said to be current and within

guidelines.

- This policy focuses 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 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 recently 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* (restraint) policy and had been drafted with input from the child and adolescent mental health services provider. It referenced the Royal College of Nursing guidance.
- The senior matron told us there was a recently introduced an *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.
- 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 representations from the safeguarding team.
- The Neonatal Intensive Care Unit used a neonatal PEWS chart to identify deteriorating babies.
- 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.
- Trust data showed between July and September 2018, there were 130 child breaches of the four-hour time from booking to receiving treatment in total on both sites. The longest time to assessment for the patients who breached was 97 minutes with another at 66 minutes and more in the 50-60-minute range.
- 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. *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 planned staffing levels for Channel Day Surgery Unit was two paediatric nurses three times a week when there were paediatric lists. Staff told us planned staffing levels were not always met and healthcare assistants often came down from Padua ward to cover. This did not meet the Royal College of Nursing 2013 guidance, *Defining staffing levels for children and young people's services*. It states there should be two registered children's nurses at all times in all children and young people's inpatient and day care areas. Staff in the Channel Day Surgery Unit could look after 12 to15 children a day, as there was a maximum of six children per morning and evening list plus two to three children daily from Padua ward.
- There was one dual trained nurse in main recovery who looked after adults and children post operatively. This was not in line with the Royal College of Nursing standards which state there should be at least one registered children's nurse in recovery during children's operating lists.

- Staff reported unsafe staffing levels on Padua ward due to a high turnover rate. Staff reported no themes in the reason for staff leaving, the majority had secured employment in other areas of the trust.
- Staff gave examples of working beyond their contracted hours and missing lunch breaks due to unsafe staffing levels. Ward management stated their biggest risk on the ward was insufficient staffing levels.
- On Sunday 21 October, Padua ward was closed due to unsafe nursing staff levels. Staff reported they stayed an extra two hours on one shift and had one 30-minute break during this shift. There were two paediatric nurses, two agency nurses looking after a total of 24 patients with seven patients on home leave.
- The children's accident and emergency department was operational between 7.30am and 2am. These hours were split into three shifts times; 07.30am to 8pm, 10am to 10.30pm and 4pm to 2am. On the night of our unannounced inspection on 24 October 2018, there were no nursing staff on duty between 4pm and 2am. Children seen within the emergency department during this time were not cared for by a registered children's nurse and waited in the main adult emergency department.
- 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 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. This meant 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 with oversight from registered nurses on Padua ward situated next to the outpatient department. The Royal College of Nursing guidance document, *Defining staffing levels for children and young people's services* (2013) states that there should be a minimum of one registered children's nurse available at all times to assist, supervise, support and chaperone children.
- The trust used an electronic rostering system. Ward management told us this was pre-set to the recommended staffing levels and took account of staff skill mix. The ward took responsibility for allocating staff to the Children's Assessment Unit, outpatients and day surgery.
- Planned staffing levels for Padua ward at night was five registered nurses and one healthcare assistant. Although these staffing levels were not met on the night of our unannounced inspection (four registered nurses and no healthcare assistant), there were only a total of 15 patients overnight.
- The specialist services divisional board meeting minutes for September 2018 showed there were two full-time equivalent (FTE) band 5 vacancies and one FTE band 2 vacancy for Padua ward. The ward had appointed three band 5 nurses and interviews for a ward clerk were underway. On the day of our inspection, there were band 2 interviews taking place.
- The accident and emergency department planned to provide a dedicated children's and young people service 24 hours a day from January 2019. A new shift of 7.30pm to 8am would be introduced. Recruitment was underway and four new employees were undertaking the corporate induction at the time of the inspection. There were vacancies for a band 5 and band 2 nurse.
- The staffing data for April 2018 downloaded from the trust website showed that the overall shift fill rates were below establishment on Padua ward for day shifts and night shifts for care staff. The registered nurse shift fill rate for night shifts was shown as above establishment. There was no deficiency 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 specialist services divisional board meeting minutes for September 2018 showed there was maternity and long-term sickness leave affecting staffing levels in the Neonatal Intensive Care Unit plus 0.11 FTE band 7 vacancy, an 0.24 FTE band 6 vacancy and 1 FTE band 2 vacancy. However, the unit was over established by 1.94 FTE band 5 nurses.

- Staffing levels on the Neonatal Intensive Care Unit met the British Association of Perinatal Medicine standards which recommend one-to-one nursing for intensive care, one-to-two nursing for patients in high dependency care and one-to-four nursing for neonates in special or transitional care. Staff did not report any concerns about staffing levels in the Neonatal Intensive Care Unit.
- The staffing data for April 2018 downloaded from the trust website showed that the overall shift fill rates were below establishment on the Neonatal Intensive Care Unit for day shifts and night shifts, particularly for care staff. There was an overall deficit in the actual patient care hours compared to the planned patient care hours.

Medical staffing

- On the children's ward there was a consultant, two registrars and three junior doctors during the day. A consultant was available on the ward until 5pm but some consultants chose to stay until 9pm on weekdays.
- At weekends there was one on call consultant on Friday and Saturday and a different on call consultant on Sunday.
- A consultant of the week system was used at the William Harvey Hospital. This meant there was a consultant responsible for paediatric services from 8.30am to 5pm on a weekly basis.
- Children undergoing emergency or elective surgery were cared for on Padua ward with clinical support of the paediatric medical staff.
- The specialist division had an on-call system for paediatric consultants.
- Medical handovers occurred three times a day. Handover was consultant led at 8.30am and 4.30pm. Handover was middle grade led at 8.30pm.
- The medical handover on Padua ward was effective and concise. Staff discussed each patient in turn including children waiting in the accident and emergency department and infection control concerns. Outstanding jobs, such as reviewing blood results, were handed over.
- The specialist services divisional board meeting minutes for September 2018 showed there was one full time equivalent trust doctor vacancy at the William Harvey Hospital which was being advertised. There were no middle grades gaps.
- The anaesthetists providing care to children during the perioperative period were always children's trained consultant grade anaesthetists.
- The acute paediatric medical rota consisted of a consultant general paediatrician, a middle grade doctor and a junior trainee doctor for each day and night shift who covered Padua ward and children referred through the emergency department.
- The neonatology medical rota consisted of a neonatologist, a middle grade doctor and junior trainee doctor for each day and night shift who covered the neonatal unit.
- Ward staff reported difficulty in contacting the on-call consultant for orthopaedic surgery. Staff had to bleep the on-call consultant constantly for medical reviews and reviews prior to discharge. This was problematic for day and night shifts. Staff told us they involved the matron when this issue arose and the consultants were responsive to them.

Major incident awareness and training

- On Padua Ward, there was a fire evacuation plan displayed by the nurse's station which detailed staff responsibilities.
- Child Health had its own escalation policy to deal with surges in demand on children and young people's services. Staff were aware of this policy and knew the escalation process which depended on the level of risk identified. If the risk was severe, the ward closed to new admissions and staff followed an action plan for this process. Staff reported this process as being very time consuming which put them under added pressure when already managing a ward with insufficient staffing or a high acuity of patients. If the area is closed, this is discussed with the ambulance service, the other hospital sites and accident and emergency department.
- Where a recent outbreak of a potentially serious infection had occurred on the Neonatal Intensive Care Unit, 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.

Safety Thermometer

- Ward management 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.

Are services for children and young people effective?

Requires improvement

We rated effective as Requires Improvement because:

- Fifty-one percent of policies relating to neonatal intensive care were overdue for review.
- The compliance rates for appraisals were worse than the trust target for the children's ward and the Neonatal Intensive Care Unit.
- There was confusion amongst staff on how to access policies and guidelines.
- Clinical audits were not being completed within the scheduled timeframes which meant there were no current performance indicators for the trust against national standards.
- National guidelines were not being followed such as the *Standards for Children's Surgery* (2013), the RCN clinical practice guidelines for pre-operative fasting and *Standards for Children in Emergency Care Settings* (2018).
- The service performed slightly worse that the national median in the Royal College of Emergency Medicine 2017/2018 paediatric pain audit.
- Nutritional screening tools for the assessment of malnutrition were not always completed accurately.
- There was no dedicated play specialist for the paediatric emergency department.
- Although a policy on therapeutic holding (restraint) had been introduced, staff had not received training around this.
- Ward rounds were not multidisciplinary which was a missed opportunity to plan and co-ordinate patient care and treatment.
- There were no paediatric trained nurses in the paediatric emergency department between 2am and 8am which meant children were cared for in the adult emergency department.

However:

- The trust performed in line with other similar trusts in the *National Neonatal Audit* 2017.
- The service used a variety of age related pain assessment tools for children to communicate their pain thresholds.
- The service employed a lead for breastfeeding who provided practical advice on feeding and signposted mothers to support forums.
- The trust performed similar to all other trusts in the 2016 children and young people CQC survey.
- All the staff we spoke with had a sound understanding of the need for informed consent to be obtained before providing care or treatment.

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.

- 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.
- 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.
- Medical staff on the Neonatal Intensive Care Unit showed us how they accessed policies and protocols via 'SharePoint', however staff reported difficulties in accessing the system. The chief nurse reported the trust had recently moved all policies from one portal (SharePoint) to another (4Policies). All but one of the Child Health directorate policies were in the new portal. Staff had not been effectively communicated with about these changes.
- Staff in the Neonatal Intensive Care Unit were still accessing the old portal which contained many policies that were overdue their review date. This included the protocol for *Neonatal Blood Spot Screening* which was due for review 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. Other expired policies included *Therapeutic Cooling* (2013), *Electrolyte management* (2011), *Seizure* (2011). In total we saw 26 policies and protocols that were out of date between 2011 and 2017. This meant staff may follow guidance which is out dated and not in line with national guidance.
- Staff told us a consultant paediatrician took the lead in updating policies and procedures related to the Neonatal Intensive Care Unit in line with national guidance. Staff told us each policy requiring an update was given a priority colour rating either red, amber or green. Policies identified as over their review date were not transferred to the new portal.
- There were 67 policies identified for review during the transferring process. At the time of our inspection, 49% were now in date (they had been ratified by the neonatal clinical guideline group), 18% were past their review date by less than three months or were being reviewed and 33% were past their review date by more than three months.
- The trust submitted data to be included into surveys undertaken by the national confidential enquiry into patient outcome and death (NCEPOD). This included *Each and Every Need* a survey into the quality of care provided to patients aged 0-25 years old with chronic neuro-disability published in March 2018. Recommendations made by NCEPOD were discussed at the monthly specialist services divisional board for Child Health.
- 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%.

Pain relief

- Staff recorded pain scores in patients' records; all patient records we looked at showed staff assessed the child's level of pain when observations were taken. There were a variety of pain tools displayed on the back of observation charts for children to use to communicate their pain thresholds dependent on their age. For example, a child could point at a scale line from 0-10, ten being the most painful, or they could use 'smiley faces', where the child chose a face that best described their own pain
- The Royal College of Emergency Medicine 2017/2018 paediatric pain audit at the William Harvey Hospital showed 27% of children had their pain assessed within 15 minutes of arrival. This was slightly worse than the national median of 29%. The reason for not administering pain relief was not documented in any of the notes audited. The trust had an action plan which was in line with recommendations from the national audit. These included re-audit in April 2019 and discussion of the results in the next paediatric team day.
- The results of the paediatric pain audit were discussed at the July 2018 urgent care and long term conditions governance and patient safety meeting.

- The trust audited compliance to assessing pain as part of the paediatric early warning score audit. The latest audit showed 78% of children on Padua ward and 83% of children on the Children's Assessment Unit had a pain score recorded with their first set of observations.
- Parents and patients on the ward told us that staff managed pain well and provided pain relief upon request.

Nutrition and hydration

- Padua ward used a nutritional screening tool for the assessment of malnutrition in paediatrics. The tool was used for hospitalised children aged between two and 16 years old, to ensure children at risk of being obese or malnourished were identified. Although staff completed this for each child upon admission, we saw the risk assessment was not always calculated correctly. For example, a child with cystic fibrosis should score two in step one, however staff had scored this child zero. This meant children at risk of malnutrition or obesity might not be identified.
- The nursing staff on Padua 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. The same procedure was followed for children attending the day surgery unit.
- There were comments within the friends and family test for Padua ward in October 2018, which showed the provision of food could be better for breastfeeding mothers. Another comment, mentioned there should be better control of the snack trolley especially for children with diabetes.
- Padua ward employed a band 4 member of staff who was the lead for breastfeeding. The lead provided practical advice on feeding and signposted mothers to support forums. Mothers had access to express pumps and a milk fridge during their baby's hospital stay. The housekeeper in charge asked families every morning whether the mother was breast feeding and informed the breast-feeding lead.
- Two parents on Padua ward reported the provision and quality of the hospital food was good.
- The trust had a policy on infant feeding and baby weighing. Staff we spoke with spoke positively around supporting mothers on their feeding choices. Mothers with babies on the neonatal unit were encouraged and supported to express milk for their babies. If women wished to bottle feed sterilisers were available and they were advised to supply their own formula milk.
- On the Neonatal Intensive Care Unit, we looked at five fluid balance charts. They were well completed including daily calculation of the overall fluid balance.

Patient outcomes

- There were 20 audits related to children and young people scheduled to be completed between April 2018 and March 2019. Of these eight had been carried forward from the 2017/2018 audit schedule. At the time of our inspection, three audits were completed.
- There was no data for the trust for the *National Paediatric Diabetes Audit* 2016/2017 contained in the information available from the healthcare quality improvement partnership. The trust last participated in this audit in 2015/2016.
- The clinical audit department reported quarterly on each directorates progress against the audit schedule.
- The women's and children care group quarter two report showed the *Paediatric Pneumonia National Audit* for 2016/2017 was complete. The aim of the audit was to assess whether the British Thoracic Society guideline is being adhered to and to identify any trends over time, both positive & negative. There were no outcomes for this audit as the compliance was acceptable.
- The women's and children care group quarter two report showed the *Autism Spectrum Disorder Diagnostic Pathway Audit* for 2016/2017 was complete. The aim of the audit was to measure current practice in autism: recognition, referral and diagnosis of children and young people on the autism spectrum against national guidance and the new local diagnostic pathway from referral to assessment/diagnosis and follow up within the children's assessment centre at Kent and Canterbury Hospital. The outcomes for this audit were to re-audit the pathway regularly, to

undertake a re-audit to look at specific time intervals between referral, a screening questionnaire being sent out and to look into the possibility of developing electronic screening questionnaires.

- The women's and children care group quarter two report showed the *Feeding Clinics Audit* for 2017/2018 was complete. The aim of the audit was to measure the performance level of services being provided by the multidisciplinary feeding clinic teams. The outcome for the audit was to undertake a re-audit.
- Survey results published in November 2017, showed the trust performed similar to all other trusts in the children and young people CQC survey on all but one question. It performed worse than other trusts for, "Did the hospital give you a choice of admission date?". This survey looked at the experiences of children and young people who received inpatient or day case care during October, November and December 2016. There were 270 responses at the trust.
- In the 2017 *National Neonatal Audit*, based on data for January 2016 to December 2016, the hospital performance was within the expected range nationally.

Competent staff

- The five-month total to August 2018 showed that the acute children's team at the William Harvey Hospital had an appraisal rate of 35%; Padua ward was 77% and the Neonatal Intensive Care Unit was 79%. These compliance rates were worse than the trust target of 85%.
- Despite the low appraisal rates, staff we spoke with were positive about the process and felt appraisals were beneficial as it was an opportunity to obtain feedback and highlight strengths and weaknesses.
- Link nurses on Padua ward found it difficult to attend training and one link nurse reported having not attended any training for the link nurse role, but they expressed an interest in the role and so they were appointed.
- Ward staff reported being assigned as the nurse in charge without prior support or shadowing. One nurse was not confident about undertaking this role but had been encouraged as it was a development opportunity.
- The trust was not meeting the recommendations of the intercollegiate guidance*, Facing the Future: Standards for Children in Emergency Care Settings* (2018). Emergency clinicians with responsibility for the care of children had received limited training in how to assess risk and immediately manage children's mental health needs and support their family/carers. A two hour training session was provided between April and August 2017 to 86 members of staff across the trust. However, staff had received no training in consent, confidentiality and mental capacity of children.
- While there was a very recent policy on therapeutic holding (restraint) which focussed on the principals and not the practice; there was no training around this and that posed a risk to both staff and children.
- *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 Padua ward but there was no dedicated play specialist for the emergency department.
- Senior medical staff, including consultants, actively provided teaching and supported the educational needs of junior staff or medical students. There was active teaching at the bedside during ward rounds.
- Newly qualified staff were supported into their new roles. All new staff completed a preceptorship course. The Department of Health define preceptorship as "a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning". New staff completed a competency workbook and attended study days. However, staff reported it took a long time for competencies to be signed off.
- The September 2018 minutes of the specialist services divisional board for Child Health meeting showed that the appraisal rate was 84% across the trust (not split by staff group or site). This was slightly worse than the trust target of 85%.
- On Padua ward, some band 5 nurses took the responsibility for the appraisals of band 2 healthcare assistants. Staff reported they received training for this role and it was viewed as a development opportunity.

- In the accident and emergency department, newly qualified nurses were supernumerary for the first six weeks and were supported throughout by a senior member of staff. This helped newly qualified nurses to familiarise themselves with the environment and their role and responsibilities.
- All staff in main theatre recovery and in the Day Channel Surgery Unit had paediatric immediate life support.
- Ward management kept a database to track individual staff compliance to core skills training modules. Registered nurse compliance to training was generally better than band 2, 3 or 4 compliance. Staff who had completed training but not the associated competencies were highlighted within the database.
- We were told that the streaming nurse did not see children unless they were a senior band 5 nurse and they decide 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 confirmed they had no competence assessment or experience of assessing children.
- Data from the trust showed link nurses attended additional training for their roles. For example, the moving and handling link nurses attended a three-day course and we saw all four members of staff on the Neonatal Intensive Care Unit had completed this.
- Staff in the Neonatal Intensive Care Unit attended specialist courses to develop their skills and knowledge. Staff had the opportunity to complete the neonatal intensive care course as well as standalone study days such as the UNICEF baby friendly initiative study day and the baby bereavement study day.

Multidisciplinary working

- Ward rounds were not multidisciplinary. The ward round was consultant led and only attended by medical staff despite other healthcare professionals such as the ward pharmacist and nurse in charge being available on the ward. This was a missed opportunity to plan and co-ordinate patient care and treatment.
- 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 but the minutes show the findings raise questions but does not provide clear answers to those questions. The minutes showed there was no neonatal palliative care guidance for the trust and said it needed to be formulated but this 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.
- The Neonatal Intensive Care Unit had an outreach service, where babies discharged from the unit were followed up by the community neonatal team. The neonatal team worked closely with community based services to ensure care was transferred effectively to community services.
- There were detailed and concise multidisciplinary handovers in the Neonatal Intensive Care Unit. The unit manager discussed key messages such as safety updates, activity within maternity and any clinical concerns. There was senior oversight and good delegation of tasks with a clear plan for the day.
- The trust had a policy for the *Management of Adolescent Transitional Care*. 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.
- The trust told us there was psychiatric liaison services available to the ward 24 hours a day, seven days a week.

Seven-day services

- The accident and emergency department planned to provide a dedicated children's and young people service 24 hours a day from January 2019. A new shift of 7.30pm to 8am would be introduced.
- The Children's Assessment Unit was open from 9am to 9pm Monday to Friday. Outside of these times the advanced nurse practitioners worked from the children's emergency unit and supported staff there. This meant 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 less suitable emergency department environment.
- The pharmacy department was open seven days a week and provided advice during office hours. Out of hours, there was an on-call pharmacist.
- Padua ward and the Neonatal Intensive Care Unit operated a 24-hour service.
- Channel Day Surgery Unit operated three times a week and was closed at weekends.

Access to information

- Medical and nursing staff expressed concerns about access to trust policies and procedures. Staff showed us how they accessed these using SharePoint. We saw the majority of policies on this platform were overdue for review. We escalated our concerns to the chief nurse who reported the platform for accessing trust policies had changed within the past two weeks and staff access to SharePoint should have been disabled. However, this had not happened.
- Agency staff who worked set shifts had access to the trust's IT systems.

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.

Are services for children and young people caring?

Good

We rated caring as Good because:

- Staff worked together to plan care and there was shared decision-making about care and treatment.
- Staff interacted well with babies and used different methods of distraction to keep them calm.
- Children and young people services did consistently well in the friends and family test.
- Feedback from parents during our inspection was generally positive about the staff attitude.

However:
- There was an inadequate psychology service for children with diabetes.
- There was no provision of a play specialist in the emergency department.

Compassionate care

- During ward round, the consultant used distraction techniques, such as pulling silly faces, to keep the baby calm while carrying out medical examinations.
- We observed one child pointing to one of the doctors during ward round and wanting to be picked up by him. The child was upset when the doctor had to review the next child on the ward. This showed staff formed special bonds with children in their care.
- We spoke with four children and their families on Padua ward. All parents reported clinical staff were caring, attentive and really good. However, one parent reported 'the dinner lady was rude last night and stated there was no hot meal available for my child.'
- The ward operated open visiting times for parents and relatives. Other visitors were requested to leave by 8pm.

- English was not the first language of one parent. We saw the feeding plan hung by the child's bedside was in English and the parent's first language. This ensured the parent was involved in the child's treatment plan.
- In the paediatric emergency department, we observed a supernumerary nurse using bubbles to calm a distressed baby. She sang a nursery rhyme to the baby and the paediatric doctor joined in.
- In the Channel Day Surgery Unit there was a side room which staff used for children with autism to minimise their distress of the sights and sounds of the unit. The unit prioritised children with additional needs or very young children on the theatre list.
- Children could wear their own pyjamas to theatres, however this practice was not embedded and we saw children wearing hospital gowns during our inspection.
- While generally, operational staff showed understanding and a non-judgmental attitude when caring for or talking about patients there were incidences whereby staff expressed their views of parents in front of the children.
- The August 2018 specialist services divisional board for Child Health meeting minutes showed 98% of friends and family would recommend Padua ward. One comment praised "the professionalism, care, nurturing and communication" that they received during their son's stay. Another reported there were "amazing discharge speeds". However, one comment stated, "The place is filthy" and another, "Sometimes it felt like a few more staff would help a lot".
- The friends and family test for Padua ward in October 2018, showed a decline in recommendations to 88.6%. There was a total of 35 responses. Comments included, "helpful and professional" and "all of the staff went above and beyond". However, comments for improvement included, "parents with small children should be offered food," and "learn parents' names as mum and dad is very impersonal".
- Padua ward encouraged feedback from children. Thirty-five children provided feedback in August 2018. We saw comments such as "I've enjoyed my stay because the nurses have been the best".
- The specialist services divisional board for Child Health meeting minutes showed 100% of friends and family would recommend the dermatology outpatient clinic with comments being positive about the running time of the clinic.
- The specialist services divisional board for Child Health meeting minutes showed only 78% of friends and family would recommend the paediatric emergency department with negative comments regarding the lack of space and heat.
- The Neonatal Intensive Care Unit sought parental feedback using an online survey. It invited parents to provide the unit with ideas on how they might improve the care it provided for babies and their families. We saw comments such as "make information regarding reduced parking/food vouchers more accessible" and "making parents more aware of any social media platforms that are there for support."

Understanding and involvement of patients and those close to them

- The consultant had a good bedside manner and explained everything to the parent/s and allowed for them to ask questions. He managed their expectations around discharge, explaining the time involved to produce a discharge letter and obtain medicines from pharmacy.
- Plans made during ward round was clearly communicated to parents and care plans were made with the involvement of the child and their parent/s.
- Young people up until the age of 16 were cared for within in the service. Young people over the age of 16 would be consulted about whether to remain on a children's ward or whether an adult ward would be more suitable.
- On Padua ward, parents told us they were able to ask questions, were 100% involved in decision making and felt well informed about the treatment plan.

Emotional support

- The lack of a play specialist in the children's emergency department was likely to impact on the emotional support available to children and young people.
- 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 schools 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 provision of service to meet the needs of children with mental health was insufficient.
- There was confusion within the paediatric emergency department about the flow of children through the department.
- The children's admission policy was unclear about the process for 16-year olds.
- Due to a lack of space, the taking of observations and administration of medicines were being undertaken in the family waiting room rather than the cubicle.
- Referral to treatment times were poor and resulted in children receiving delayed assessment and treatment.
- 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.
- There was limited recognition of the needs of children and young people with learning difficulties or autism. There were identified link nurses but they had not received any training.
- Staff were unaware of any communication aids available to them.
- 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 19 years of age.
- Learning from complaints was not always comprehensive to enable improvements to the service.

However:

- The trust had a flagging system for children with learning disabilities so patients arriving in accident and emergency departments would be identifiable.
- The outpatient department had many clinics to meet the needs of the local community.

Service planning and delivery to meet the needs of local people

- Elective and emergency surgery was carried out at the William Harvey Hospital which reduced the need for travelling to more distant centres. The journey children needed to take to the operating theatres was not 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 William Harvey Hospital was not adequate to meet the needs of the local community. There was not a contact for mental health from the other NHS trust available on site for children which meant the responses were slower than for adults.
- The children's emergency department and Children's Assessment Unit were not planned to enable staff to meet the needs of the local population.
- The outpatient department had many clinics to meet the needs of the local community.

Access and flow

- The flow of children and their pathway through the emergency department was confused and not well understood by staff. Senior staff described a completely different pathway to that understood by frontline staff.
- 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.
- 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 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.
- The senior matron told us that, "Children were not meant to mix with adults".
- There was a GP based in the emergency department and sometimes if the children's emergency service was busy streaming, patients were sent there. A GP was in the department from 10am to midnight Monday to Saturday.
- The streaming nurse (when seeing children) saw everyone in order of arrival to the department. 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 department 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 their care and treatment.
- 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 while 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 discharged 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 from the ward or a clinical technician in the children's emergency department who provided one to one care.
- 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 or clinically indicated.
- We spoke with a family whose 13-month-old child was attending a follow up appointment. They had waited three hours in the adult waiting area when they first brought the child to the accident and emergency department two days earlier.
- 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 here.
- The Children's Assessment Unit was a five cot/trolley bay and a single room which was usually managed by an advanced nurse practitioner and a band 5 nurse. The band 5 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 the child death overview panel pathway but this 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.

- The current trust waiting list at August 2018 was 1,511 for outpatient appointments and no inpatient waiting list. The backlog was 151 with a suggested time to clear the backlog of one week. The calculated wait was 13 weeks for outpatient appointments.
- Sixty eight percent of patients were seen within 12 weeks which was 7% better than the preceding month.
- Ninety percent of patients were seen within 24 weeks which was the same as the preceding month.
- The referral to treatment time in August 2018 showed that there had been 66 breaches of the 18-week target for general paediatrics, seven for community paediatrics, 38 for community paediatric neuro-disability and 7 for paediatric cardiology. This meant there had been a total of 118 breaches of the 18-week target where patients were still awaiting an outpatient appointment.
- There were a further 62 patients where the outpatient appointment 'was still ticking' and overall a total of 180 breaches of the target with 9 over 35 weeks and zero over 52 weeks.
- Compliance with the two-week wait for suspected cancer referrals was 92% compliant in August 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.
- The Neonatal Intensive Care Unit was closed to new admissions at the time of our inspection due to infection.
- In the Channel Day Surgery Unit there was only one area for children preoperatively and post-operatively. This meant children waiting to have surgery shared facilities with children recovering from surgery.
- Children were escorted from Padua ward to main theatres by a porter, a ward nurse and their parent/s. Children would take priority on the theatre list and would be seen first.
- One parent could accompany their child into the anaesthetic room.
- After surgery, parents were invited to come to recovery. Children would be taken to the two-bedded paediatric recovery area after surgery. This area was not child friendly as the children would not be shielded from the sights and sounds of adults recovering from surgery.
- Ward staff reported delays in the transfer of children from the emergency department to the ward. Barriers to this included low staffing numbers which meant children weren't discharged efficiently, beds were not cleaned or made ready in time or staff were waiting on discharge letters for children waiting to go home which blocked the bed for the next child.

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.
- 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 and did their best while the child was in their care awaiting transfer to a mental health bed. Most of these children were discharged within 24 hours of admission.
- The poor access to mental health advice and assessment meant children and young people did not always get the necessary emotional support.
- 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. 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.

- The intercollegiate guidance document *Standards for Children's Surgery* 2013 states that procedures should minimise anxiety for the child. For example, 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 the William Harvey Hospital 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.
- The ward was separated into age groups which meant children were accommodated with peers. Bays for teenagers were segregated by gender which maintained their privacy and dignity.
- 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.
- Children with autism or learning disabilities were prioritised on the theatre lists and would be put as the first procedure of the day. There was a separate cubicle on the ward and in the Channel Day Surgery Unit that were allocated to these children.
- Staff told us that they had no training in caring for children and young people with learning disabilities. The ward had a learning disability champion, however they had not received any additional training for this role but had spoken with the learning disability practitioner for the trust. Staff told us children with learning disabilities were treated the same as all the other children on the ward and additional needs were met by their parents.
- 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, staff should encourage the parents to liaise with the child's school or the trust could refer to Kent health needs education service.

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 were closed within the agreed timescale with the client.
- 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.

Are services for children and young people well-led?	Inadequate

We rated well-led as inadequate because:

- The services did not have a clear vision or strategy.
- Continuous improvement, and learning from when things go wrong was not evident across all areas.
- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Not all risks identified during the inspection were documented on risk registers and those that were did not have adequate mitigating factors in place.
- 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 a particular outlier. Therefore, risk management and oversight was limited.
- The NHS Staff Survey results for 2017 showed that overall the trust was in the worst 20% of trusts nationally for staff engagement.

However:

- Most managers promoted a positive culture that supported and valued staff. There was good teamwork amongst staff and staff strived to support their peers.

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 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. Staff on Padua ward were aware of the consultation and were invited to attend.
- 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 using social media and parents talking at board meetings about their experience of the service. They said 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 vision and values of the specialist services division was displayed on the front of the monthly newsletter, however staff we spoke with did not know the vision and values.

Governance, risk management and quality measurement

- 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.
- Ward management told us auditing was a work in progress. Audits for bare below the elbows and information governance were partially done. This showed a lack of commitment and understanding of the use of audits to measure quality of care. Nursing staff were not proactive in auditing processes and ward management acknowledged there was scope for nurses to be more involved.
- 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.
- The pathway of 16 to 18-year olds. We were told that the trust had taken urgent action with the medical team to rectify the current pathway.
- 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.

- The highest risk on the divisional risk register, reported in the specialist services divisional board for Child Health meeting minutes for July 2018, showed 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 recorded a known risk of harm to a child due to use of adult bed rails on adult beds in paediatrics. This had been recorded as a risk in August 2018 by the senior matron for child health. The reports suggested that all staff were aware of the risks and that adult trolleys were not used for children under two years of age. We found that at the William Harvey Hospital adult trolleys were in use for babies and children under two and that staff had no understanding of the risk this posed.
- 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 incidents and provided false assurance.
- Vital signs audits were undertaken and showed poor performance, The October 2018 audit showed that the 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 30% against a target of 100%.
- The action plan from the September 2018 audit is insufficient to address the continual poor performance and does not identify 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 Paediatric Early Warning Score 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". This meant the actions to address the concerns were ineffective and had been allowed to continue for at least 12 months.
- 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. This meant the senior management team could not identify specific hotspots or areas requiring improvement.

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 children's services and an operational director (interim).
- Reporting to the senior matron was a band 8a matron who covered the inpatient and outpatient's 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.
- 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.
- Staff on the Channel Day Surgery Unit felt unsupported. They reported frequent occasions of having unsafe staffing levels but insufficient actions taken to mitigate the risk such as the use of a healthcare assistant instead of a qualified paediatric nurse.
- The Padua ward manager was supernumerary on the staff rota. This enabled the ward manager to aid the ward or other departments if required. Staff were very positive about the ward manager and stated they were approachable and that they felt supported.
- 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.
- Ward staff reported looking at the rota and feeling anxious about shifts they could see had fewer than planned staff rostered. Some reported dreading coming into work and coming into work when they were unwell as they did not want to let the team down.
- We asked staff what made them proud to work at the trust, however not all staff could provide an answer to this question.
- Ward management felt extremely stressed but felt listened to and supported. They stated their team were engaging and supported what they were trying to do with the service.
- One nurse reported feeling 'cuddled' back into ward when she returned from maternity leave. She was enabled to shadow a nurse for her first few days which helped to ease her back into work.
- Amongst staff there was clearly a supportive culture with staff working additional unpaid hours and taking on additional tasks to support their peers.

Equalities and Diversity – including Workforce Race Equality Standard

- For the key measure, “In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?” the performance was in line with other trusts.
- The survey showed that 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

- Staff received a monthly specialist services division newsletter. The newsletter was used to communicate key updates, team achievements, training dates and to introduce new staff.
- 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.
- For key findings related to equality and diversity the trust performance was in the worst 20% of trusts nationally.
- 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.

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 19 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 regular and comprehensive training in meeting the needs of children and young people with mental health disorders, 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 of the 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.