Buckinghamshire Healthcare NHS Trust

Stoke Mandeville Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Stoke Mandeville Hospital

Inspected but not rated

We did not rate the service at this inspection.

We found that:

- Paediatric staff had training in key skills. Staff usually assessed risks to patients, acted on them and kept good care records.
- Leaders ran services well using reliable information systems. Staff felt respected, supported, and valued.
- The service did not always have the optimum number of staff but had procedures in place to ensure the levels were safe.

However:

- The service did not always thoroughly review and investigate incidents. This meant that areas of improvement and learning were not always identified to prevent further occurrences.
- Staff did not always use translator services when required, and there was no accessible information to inform children, young people and their families this service was available. This meant there was a risk of breakdown in communication which could impact on understanding.
- Staff were not always clear about their roles and accountabilities when reporting incidents according to trust's own policy.

Urgent and emergency services

Inspected but not rated

Buckinghamshire Healthcare NHS Trust (BHT) provides acute hospital and community services for people living in Buckinghamshire, as well as some people living across the borders in surrounding counties. The trust has 2 acute hospitals, Stoke Mandeville Hospital which is in Aylesbury, and Wycombe Hospital which is in High Wycombe.

The trust had won a bid for £15 million of capital funding to enable them to build a new children's emergency department (ED), and to improve the maternity and gynaecology facilities at Stoke Mandeville Hospital in 2020. This had opened on 24 April 2023. The new facilities provided a children's ED and a children's observation unit (COU), which had freed up more space within the adult emergency department. It was open 24 hours a day, 7 days a week.

We carried out an unannounced focused inspection of the children's emergency department within Stoke Mandeville Hospital. We had received information of concern which suggested an early recognition of sepsis did not always take place and investigations were not always thorough and learning robust. As this was a focused inspection, we did not inspect all key questions. We looked at aspects of the key questions under safe and well led. We looked at:

- Assessing and responding to patient risk, and appropriate escalation of patients.
- Record keeping.
- Staffing levels and skill mix.
- Investigation of incidents and learning from incidents.
- Management of risk.
- The provision and use of translator services.
- The culture of the service.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills, including the highest level of life support training, to all staff and made sure everyone completed it.

Most paediatric nursing staff received and kept up-to-date with their mandatory training. Overall compliance with statutory and mandatory training was 97% in March, 96% in April and 98% in May 2023. Mandatory training is compulsory training that is deemed essential by an organisation for the safe and efficient delivery of services. Statutory training is training which is required by law or where a statutory body has instructed an organisation to provide training on the basis of a specific legislation.

Advanced Paediatric Life Support (APLS) training had been completed by 71% of paediatric nursing staff. APLS training was paused during the COVID-19 pandemic, as it was face to face training. APLS training provides the knowledge and

skills necessary for recognition and effective treatment and stabilisation of children with life threatening emergencies. Training in paediatric sepsis had been completed by 95% of paediatric nursing staff and training on the use of the Paediatric Early Warning System (PEWS) had been completed by 92% of paediatric nursing staff in May 2023. PEWS helps with early recognition of sick children and identification of any deterioration in their condition.

Paediatric medical staff received and kept up to date with their mandatory training, demonstrating 100% compliance in training in APLS, paediatric sepsis and PEWS training.

However, children were occasionally seen by general emergency department medical staff. In May 2023, 46% of all general emergency department medical staff had completed paediatric sepsis training and 56% had completed training in the use of PEWS. Junor medical staff had not completed training in APLS.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

The design of the environment followed national guidance.

The new paediatric emergency department opened in April 2023. It included a children's observation unit (COU), which had 10 rooms holding 14 bed spaces, 1 dedicated room designed for the treatment of children or young people with mental health needs and a double-bedded resuscitation unit, which was used exclusively for children. There was a dedicated entrance for babies, children and young people arriving by ambulance. The new children's emergency department was clean, bright, and spacious.

The COU was used for children and young people who did not need to be admitted to the children's ward but required a period of up to 24 hours for observation and treatment. The design of these rooms followed guidance in health building note 00-03, with ensuite bathroom facilities, and plenty of space for storage of their belongings and accompanying family members. Oxygen, medical air, and vacuum outlets were in place within each room and each bed had access to a call bell. Single rooms were used for children and young people who may be infectious. The multi-bedded rooms had privacy curtains around each bed.

The sluice room and storeroom of the department had 'Jack and Jill' access, so they could be accessed from both the children's emergency department and the COU. The department had a medicines room which was accessed using keys which had been programmed for each staff member including agency staff. This ensured traceability to who had accessed the room and at what time.

The resuscitation room contained 2 resuscitation bays and followed health building note 15-01 and guidance from the 2010 resuscitation guidance from the Resuscitation Council. There was unimpeded access to the resuscitation room from the ambulance entrance. Each resuscitation bay was large, to accommodate the numbers of staff required to care for patients, and to house all necessary equipment and medicines required to safely treat critically unwell children and young people.

Staff carried out daily safety checks of specialist equipment. We saw that daily and weekly audits had been carried out on the resus trolleys. There were 3 resus trolleys readily available within the department.

Assessing and responding to patient risk

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Staff completed risk assessments for children and young people swiftly. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff completed risk assessments for each child or young person on arrival, using a recognised tool, and reviewed this regularly. Children attending the emergency department between the ages of 1 month and 16 years were initially assessed within the Urgent Treatment Centre (UTC). The UTC was staffed by a streaming nurse between 8am and 8pm each day within a dedicated children's waiting area. The streaming nurse was a trained paediatric nurse. They had oversight of the children and young people in the waiting room, which meant they could monitor and assess for deterioration. The streaming nurse followed the streaming pathway for children, which was based on the Manchester Triage System. The use of the Manchester Triage System ensured a consistent approach to assessment and prioritisation. This meant children and young people were seen in order of clinical priority and not in order of attendance. The streaming checklist was clearly displayed within the assessment area. This highlighted criteria for those who were required to be on the rapid paediatric pathway, which included:

- All babies under 1 month old
- Babies under 3 months of age with a body temperature of below 36 degrees Celsius or above 38 degrees Celsius.
- First febrile convulsion in children under 18 months of age.

The service's triage standard was that a face-to-face encounter should occur within 15 minutes of arrival and should take less than 5 minutes to complete. Triage consisted of a set of observations which included, but was not limited to, temperature check, respiratory rate, heart rate, blood pressure and capillary refill time (CRT). CRT is defined as the time taken for colour to return to a finger after pressure is applied to cause blanching and is widely used to assess the circulatory system in unwell children. The patient record proforma used within the UTC asked the streaming nurse to consider 'could this be sepsis?' This box was ticked if the initial observations raised concerns about a potential sepsis diagnosis. Based on this initial examination, patients were either streamed to the children's emergency department or seen within the UTC by a team of general practitioners (GPs). Those children and young people assessed as requiring urgent care were accompanied by the streaming nurse directly to the children's emergency department. The streaming nurse requested other staff within UTC to cover the paediatric waiting room while this took place. Children and young people who remained within the UTC were re-examined at regular intervals to ensure that they did not deteriorate while waiting to be seen by the GPs.

Children and young people who had been seen within 48 hours could report directly to the children's emergency department if they were returning with the same condition. Children and young people would present directly to the children's emergency department between the hours of 8pm and 8am, when the paediatric streaming nurses were not working within the UTC.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used Paediatric Early Warning System (PEWS) to aid with the early recognition of sick children and identify any deterioration in their condition. The PEWS system looked at the patient's respiratory rate, oxygen saturation, heart rate, CRT, blood pressure and temperature. In addition, the PEWS system considered a patient's AVPU score:

A - is the patient awake/sleeping normally?

V - does the patient respond to verbal stimulation?

P - does the patient respond to painful stimuli?

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U - is the patient completely unresponsive?

Staff followed the PEWS escalation plan, which was documented on the PEWS chart. Observations were repeated at intervals which were indicated by the PEWS score. Staff demonstrated a good knowledge of what they would do if a patient's PEWS scores required escalating. We saw observations were repeated in line with the PEWS score in each of the 12 patient records we reviewed.

Staff told us that electronic devices were going to be introduced later in the year to record PEWS scores. The electronic devices would upload the PEWS scores automatically onto electronic white boards within the nurses' stations, so nurses could visualise which patients were most at risk of deterioration. They would also highlight when patient observations were due to be repeated. The new ePEWS system would give more emphasis to parental and clinical judgement within the scores.

The service's fever pathway - clinical assessment and management tool for children younger than 5 years old, referenced the National Institute for Health and Care Excellence (NICE) 'traffic light' system to assess a child's risk of serious illness. We saw evidence that the traffic light system was being used in patient records. A quick reference guide to the traffic light system was observed within the assessment area of UTC. It outlined the normal and high-risk ranges for respiratory rate, heart rate and blood pressure for different age ranges of children.

A sepsis screening tool was used on all patients on triage. The sepsis screening tool was an aid for staff to recognise, review, respond and reassess for signs of sepsis. The sepsis screening tool was triggered if patients presented with 2 from the following:

- Temperature below 36 degrees Celsius or over 38.5 degrees Celsius.
- Raised heart rate according to patient age.
- Raised respiratory rate according to patient age. Plus 1 from the following:
- Altered mental state: sleepy, floppy, lethargic or irritable.
- Mottled skin or prolonged CRT.
- Clinical concern indicating possible sepsis.

If the sepsis tool was triggered, the patient would be reviewed by a middle grade doctor or above. Staff told us that the sepsis screening tool would be used again if the PEWS scores changed and indicated a possible sepsis diagnosis. If sepsis was considered likely, staff followed the sepsis 6 pathway, where treatment would be delivered within 1 hour. Treatment included high flow oxygen, urine output measurements, obtaining intra-venous (IV) access, taking blood tests and blood gases, giving antibiotics and fluids.

Children were not sedated within the paediatric ED department or resus rooms. Children who required sedation were transferred to an operating theatre and the children's ward.

The service used the Southampton Oxford Retrieval Team (SORT). SORT guidelines were displayed within the resus area of the department. SORT was a collaboration between 2 paediatric intensive care units which delivered paediatric critical care to hospitals throughout the south of England.

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Shift changes and handovers included all necessary key information to keep patients safe. A safety huddle was held every weekday morning which was attended by representatives from all departments within the hospital. This meeting was chaired by the chief nurse and discussed staffing levels, capacity and any significant events that had occurred during the previous day. Staffing levels were RAG rated as red, amber, or green and staff would be moved between wards when necessary.

The service used an electronic clinical patient management programme, which helped staff monitor waiting times and communicate treatment details with the patient's GP.

Staffing

The service did not always have enough nursing staff and support staff but took steps to maintain safe staffing levels. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The number of nurses and healthcare assistants did not always match the planned numbers. Between November 2022 and April 2023, 571 shifts were required to be filled by agency or bank staff across the paediatric department. The review of data showed of these 571 shifts, 15% were unfilled. The service had no incidents which related to a shortage in nursing staff in the year preceding the inspection.

The department manager could adjust staffing levels daily according to the needs of the children and young people. A specific paediatric huddle was held between the paediatric ward and ED department at 3 hourly intervals each day. This meant that the departments could adjust staffing levels to meet extra demand when required. Staff followed the service's acute bed management policy for addressing shortfalls in capacity and staffing. This included asking staff to alter shifts and seeking suitable staff from other areas within the trust. Managers requested staff familiar with the service. We saw that the same bank and agency staff were repeatedly used. The paediatric nurse who triaged patients in UTC told us that they worked 4 to 5 days per week as an agency nurse. They told us that managers made sure all bank and agency staff had a full induction and understood the service.

The Divisional Director for Women and Children's Health told us there had been a recruitment drive over the past 12 months, to ensure the service had a robust staff model in place.

Medical staffing

The trust used a flexible approach to maintain safe medical staffing levels, while steps were being taken to employ the additional medical staff required. Managers regularly reviewed staffing levels and skill mix.

Managers could access locums when they needed additional medical staff. Between November 2022 and March 2023, 89 shifts were filled by bank medical staff. Bank staff were used to cover for staff sickness, maternity leave, and strike action. The service had logged 1 incident in the year preceding the inspection which related to a shortage of doctors in the emergency department. This had resulted in a 10 hour wait for some patients.

The service had a good skill mix of medical staff on each shift. They reviewed this regularly. However, there was not a paediatric emergency medicine consultant, (PEM) as recommended by the Royal College of Paediatric and Child Health.

The Divisional Director for Integrated Medicine told us there had been a big recruitment drive as the paediatric emergency department had expanded once it had moved into the new building in April 2023. They understood that the service needed to invest in a bigger workforce to fulfil the transformation of the urgent and emergency care (UEC)

service. The service had plans to increase the paediatric medical workforce by an extra 2 consultants. They told us that the new paediatric emergency department would be more attractive for paediatric emergency medicine consultants (PEMs) to want to work at the service. The unit was staffed by paediatric consultants and registrars and junior doctors from the general emergency department were allocated to work within paediatric emergency department on rotation.

Twilight consultant cover was in place between 4pm and 10om on weekdays and 5pm and 10pm on weekends and bank holidays. This allowed for onsite senior decision making for more hours of the day. However, staff told us that this shift was not always filled.

To accomodate for the increased capacity of the new children's emergency department, additional consultant cover for the COU was introduced in January 2023. This meant that a paediatric consultant was available in the COU between 9am and 10pm on weekdays and 5pm and 10pm on weekends, when twilight cover was in place.

Records

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

Patient notes were comprehensive. We reviewed a sample of 12 patient records. The records were clear, detailed, and demonstrated that PEWs scores and sepsis screening tools were being used appropriately and routinely. All patient records were paper based.

Trust wide audits on patient records were carried out monthly. These audits looked at various aspects of patient records, including if pain assessments and food charts had been completed, if safeguarding screening had taken place and if the records had a legible printed name after each entry. The average score for the department was 54% in October and 55% in December 2022. Improvements had been made and in January and May 2023 the audit showed 100% compliance. The department aimed to maintain these standards and to continue the monthly audit of patient records.

Sepsis and PEWS audits were completed internally within the department and the outcomes of these audits were discussed in the Children's Emergency Department/Children's Observation Unit monthly meeting. We saw the meeting minutes for March, April and May 2023 which showed compliance with using the sepsis screening tool was between 80% and 90% and compliance with using the PEWS chart correctly was between 84% and 90%.

Records were stored securely. All records were stored on the department for 3 days before being filed centrally.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers did not always fully investigate incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They told us that incidents would be reported on the electronic incident reporting system and the divisional director of the department would be notified by email of any incidents classed as moderate or above. We saw that staff from the children's emergency department and observation unit had reported 171 incidents on the electronic incident reporting system in the year preceding the inspection. Of these incidents, 149 had been classed as no harm, 15 classed as a near miss and 7 were classed as harm occurred (6 of which were classed as low harm and 1 as moderate harm).

Urgent and emergency services

Staff did not always report serious incidents clearly and in line with trust policy. A serious incident is defined by the NHS Serious Incident Framework as "adverse events, where the consequences to patients, families, carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified." The NHS Serious Incident Framework supported NHS services to develop robust systems for reporting, investigating, and responding to serious incidents.

The trust's serious incident report form stated that the purpose of a serious incident investigation was to learn from incidents (and not to assign blame). The objectives of the serious incident investigation were to establish whether lapses occurred in care and identify any actions to reduce or eliminate any identified lapses.

Staff were directed to follow the service's paediatric, neonatal, and obstetric incident investigation flowchart. This demonstrated the steps which would be taken in the event of a possible serious incident. All incidents were to be reviewed daily by the senior nursing team, to see if they met the criteria to be a serious incident. The flowchart included a trigger list for potential paediatric serious incidents. The trigger list included, but was not limited to:

- Death of a child
- Unexpected deterioration of a patient requiring retrieval for an increased level of care
- Failure to adhere to PEWS policy and escalation.

In the year preceding our inspection, the service had reported 1 unexpected child death within the paediatric emergency department, 30 incidents which involved an unplanned transfer of care to other institutions or clinical services and 4 incidents which involved a failure to adhere to PEWS policy and escalation. From the 171 incidents, 6 had further investigation with a 72-hour report (3 of these involved a deteriorating patient which required an unplanned transfer of care) and 3 of those had been identified as serious incidents.

The service's management of child deaths guideline stated all unexpected deaths should be reported in the incident reporting system and the lead handler for these incidents should be the Sudden and Unexpected Death of a Child (SUDC) lead paediatrician. We saw that the SUDC paediatrician was not involved in the assessment of an incident following an unexpected child death. The incident report for this unexpected child death was lacking in detail, with no reasoning or explanation on why further investigations were not carried out.

It was not clear if managers investigated all incidents thoroughly. We saw from the electronic incident reporting system that an initial review of each incident was reviewed by senior staff members. The record included a description of the incident and any actions taken or lessons learnt following the incident. Some entries were clear and concise, with enough detail to support an informed decision. Most entries were clear and concise, with enough detail to support an informed decision. However, for some of the incidents which met the criteria for consideration as a serious incident, it was unclear from the records if they had been correctly identifed as not requiring further investigation.

The NHS England Serious Incident Framework states, "Whilst a serious outcome (such as the death of a patient who was not expected to die) can provide a trigger for identifying serious incidents, outcome alone is not always enough to delineate what counts as a serious incident. The NHS strives to achieve the very best outcomes, but this may not always be achievable. Upsetting outcomes are not always the result of error, acts and/or omissions in care. However, this should be established through thorough investigation and action to mitigate future risks should be determined".

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The NHS England Serious Incident Framework states that where it is not clear whether an incident fulfils the definition of a serious incident, providers must engage in open and honest discussions to agree the proportionate response. If a serious incident is declared, but further investigation demonstrates there were no acts or omissions of care which contributed to the outcome, the incident can be downgraded.

The NHS England Serious Incident Framework also states, 'Those involved in the investigation process must not be involved in the direct care of those patients affected nor should they work directly with those involved in the delivery of that care. Those working within the same team may have a shared perception of appropriate/safe care that is influenced by the culture and environment in which they work. As a result, they may fail to challenge the 'status quo' which is critical for identifying system weaknesses and opportunities for learning.' The decisions to not further investigate potential serious incidents with a 72-hour report were made by the senior management team in the paediatric emergency department.

Staff understood the duty of candour. They were open, transparent, and gave patients and families a full explanation if and when things went wrong. The duty of candour requires registered providers and registered managers to act in an open and transparent way with people receiving care or treatment from them and includes specific requirements for certain situations known as 'notifiable safety incidents.' A notifiable safety incident must meet all 3 of the following criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity we regulate.
- In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

Formal duty of candour was not required if the incident was classed as no harm, low harm or near miss, but there was an expectation for the paediatrics team to discuss and support families following all incidents. Formal duty of candour was required if the incident had required a 72-hour report, even if the incident had been downgraded and was not classed as a serious incident. We saw that duty of candour had been formally completed in 3 incidents in the year preceding the inspection. There was no evidence that formal duty of candour had occurred for the other 3 incidents which had a 72-hour report.

Staff received feedback from investigation of incidents. There was evidence that changes had been made in response to some of the incidents reported. Where improvements were identified, actions taken to address these improvements were documented in the incident reporting system. For example, we saw that on 3 occasions, action was taken to remind staff on the importance of clear and correct documentation. This included an incident where the PEWS chart had not been completed correctly, but this had not impacted on care as the patient was escalated immediately when triaged. The junior doctor involved in this incident was informed about the importance of completing the PEWS chart correctly.

An online communications channel had been developed when the service had moved into the new unit. We saw that changes to process were communicated to staff through this communications channel. Following an incident, staff were reminded to wear red aprons when making and using medicines. The purpose of the red apron was to notify other staff that they were not to be distracted.

We saw an email which was sent to all staff at the beginning of April 2023. This reminded staff to ensure that the correct PEWS chart was used according to the patient's age. The matron planned to complete spot checks to ensure that this was happening in the future.

Urgent and emergency services

Staff met to discuss the feedback and look at improvements to patient care. Incidents and complaints were discussed at monthly PDU meetings, and service delivery unit (SDU) clinical governance meetings.

Managers debriefed and supported staff after any serious incident. Staff told us that they received support following incidents.

The trust was working towards implementing the Patient Safety Incident Response Framework (PSIRF) in Autumn 2024. This was a new approach to responding to patient safety incidents and would replace the Serious Incident Framework. PSIRF would support the development and maintenance of an effective patient safety incident response system, which would have 4 aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approached to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The paediatric emergency department sat under the Division of Integrated Medicine but was staffed by paediatric nurses from the Division of Women's and Children's Health. The Children's Observational Unit (COU) was located next to the paediatric emergency department and sat under the Division of Women's and Children's Health. Leaders were aware that as the paediatric emergency department was cross divisional, and had recently moved into a new separate building, there needed to be strong links between the 2 departments. The Divisional Director of Integrated Medicine said the arrangement could feel fragmented, as the department was staffed by paediatric nurses who sat under the Division of Women and Children and Sexual Health. The service had appointed a lead clinician who linked the 2 departments. The 2 emergency departments held 3 hourly safety meetings during the day, where capacity and demand, waiting times and safety issues were discussed, so both departments were aware of the current pressures on the service.

The nursing leadership team for the paediatric emergency department was overseen by the Head of Nursing for Acute Paediatrics. They oversaw the Acute Lead Nurse for Paediatrics, the Matron for Paediatrics, the Team Lead for the department and 15 deputy sisters or charge nurses. Staff told us the Acute Lead for Paediatrics, Matron for Paediatrics, and the team leaders were accessible and visible. Staff would raise concerns and escalate through the named manager of the day. The service had a named paediatric consultant of the week, who also managed any issues arising in the department.

Vision and Strategy

Urgent and emergency services

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust had received £15 million of funding in 2020, which was part of a £28 million package of funding to upgrade emergency departments in a bid to reduce overcrowding within emergency departments nationally. The opening of the new unit in April 2023 had a positive impact for both paediatric emergency medicine and the general emergency department, as it had freed up more space.

The Divisional Director for Integrated Medicine told us about the trust's ongoing plans to transform the Urgent and Emergency Care (UEC) service, which were in line with the NHS's UEC Recovery Plan and the NHS Long Term Plan, which was published in January 2019. This included measures to provide an urgent care service, through the Urgent Treatment Centre (UTC) 24 hours a day, 7 days a week. The UTC was crucial to stream patients arriving at the emergency department to the most appropriate pathway, which in turn relieved the pressure on the emergency departments. The Divisional Director for Integrated Medicine told us there were 5 pillars of work ongoing, which included measures on working with other community services, such as pharmacies, focusing efforts on reducing the length of stay in hospital, admission avoidance whenever possible and implementing same day emergency care (SDEC) services, to allow for rapid assessment, diagnosis, and treatment of patients. The UEC programme was still in development, but the UTC was scheduled to be open 24 hours a day from July 2023.

The Head of Nursing for Acute Paediatrics told us they attended the emergency care transformation meetings and had an input into the transformation.

Culture

Most staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear. The service did not always make sure that all people could communicate effectively.

The service participated in a national annual staff survey. The survey provided essential information to the trust about staff experience, which could be compared to other NHS trusts across England.

Staff from the Women and Children and Sexual Health Division of the trust gave a response rate of 57% in 2022. Generally, staff from the division gave scores in line with the whole trust, which was above the national average. Scores were on a scale of 0-10, with a higher score being more positive than a lower score. The whole division gave higher positive scores relating to compassion and inclusivity, feeling recognised and rewarded, and teamwork, compared to the whole trust. The division scored lower compared to the whole trust in parameters about flexible working, supporting a work-life balance and experiencing negative experiences.

However, staff from the Paediatric Division Unit (PDU) gave lower than average scores compared to other staff in the division. This included:

- Score of 4.17 in response to being recognised and rewarded for their work (compared to an average score of 6 across the whole trust).
- Score of 6.14 in response to the service being compassionate and inclusive (compared to an average score of 7.4 across the whole trust).

Paediatric medical staff scored 7.86 for compassion and inclusivity, compared to 7.4 across the whole trust and 6.68 for being recognised and rewarded, compared to an average score of 6 across the trust.

The Interim Divisional Director for Women and Children's Health told us they had seen an improvement in staff morale since moving to the new unit.

Staff told us doctors within the paediatric emergency department were approachable, and they felt part of a team. They detailed how they could escalate patients to their medical colleagues if they had any concerns. If a paediatric doctor was unavailable, they would escalate to their matron or the nurse in charge.

Junior doctors from the adult emergency department had rotations within the paediatric emergency department. A buddy system was in place, so they were supported.

Staff told us that they had input into the planning of the new unit, and they felt listened to and valued.

Between May 2022 and May 2023, the paediatric service had used interpreters 26 times (this covered the whole paediatric department, including the ward and community services). Interpreters had been arranged for Ukrainian, Polish, Punjabi, and Cantonese languages. The service had arranged British Sign Language interpreters twice within this period. One member of staff told us interpreter services were available 24 hours a day and 7 days a week. We did not see any information within the paediatric emergency department, children's observation unit (COU) or urgent treatment centre (UTC) which informed children, young people, and their families of the availability of interpreter services. The failure to provide an interpreter when required can affect patient experience and health outcomes and could result in children young people and their families feeling they had not been listened to. Trust guidelines encouraged staff to involve an interpreter, who was not a family member, when English was not understood or spoken well. A review of records demonstrated there had been some occasions when families may have benefited from an interpreter, but one had not been called.

Governance

Leaders operated effective governance processes. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The paediatric emergency department was an extension of the general emergency department. We saw meeting minutes between the emergency department and the paediatric decision unit (PDU) held in May 2023. Staff discussed the opening of the new paediatric emergency department and when children should be transferred to the children's observation unit (COU). Matrons from each department met twice a month to discuss any concerns or issues. The Head of Nursing for Acute Paediatric Medicine told us that the monthly quality and safety report from the general emergency department covered an assessment of incidents recorded by the paediatric emergency department.

Staff from the paediatric emergency department were expected to attend at least 4 paediatric decision unit (PDU) meetings per year. These meetings discussed feedback from incidents reported for the previous month, staffing and recruitment, and outcomes from audits.

Meeting minutes for the monthly paediatric clinical governance meetings were clear and comprehensive. These meetings covered incidents, learning points, paediatric deaths, the risk register, safeguarding concerns, complaints, and audits. Outcomes from the morbidity and mortality (M&M) meetings and Child Death Overview Panel (CDOP) were also discussed within these meetings. The paediatric mortality and morbidity (M&M) meetings gave a summary of each case and identified learning points and actions.

The Service Delivery Unit (SDU) clinical governance meeting for the emergency department included updates from the paediatric department. The meeting discussed incidents and complaints, learning, audits, and performance across the whole emergency department.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively.

Clinical and internal audit processes generally had a positive impact on quality governance, with clear evidence of action to resolve concerns. We saw the minutes of a PDU meeting held in May 2023 which discussed that the department had scored 80% in a sepsis audit, and 90% in a PEWS audit. Staff were reminded of the importance of completing the sepsis screening tool and to initial and outline the frequency of observations on the PEWS chart. Similar results for these audits were discussed in previous meeting minutes for March and April 2023.

We did not see any evidence the trust had clear processes in place to assure themselves that policies and guidelines relating to incident reporting and management were being followed and that incidents were being correctly categorised and investigated.

The trust's policy for the management of incidents and serious incidents outlined the immediate actions to be taken when an incident had been identified as a potential serious incident. The recommended actions included a conference call within a 48-hour period to include a member of the Division Senior Team, local manager where the incident occurred and the Divisional Clinical Governance Lead.

We saw evidence of a 48-hour report for a potential serious incident (SI) which was completed following a historic event. The decision rationale to not progress this case as a serious incident was documented and explained clearly within the report. We did not see any evidence of 48-hour reports for any of the incidents reported within the year preceding the inspection, including those which were included on the potential serious incident trigger list.

The trust had completed a serious incident and complaints, including lessons learnt audit in April 2023. However, this only looked at incidents once they had been declared a serious incident. It did not give assurances whether all incidents had been appropriately classified and investigated.

The service's policy for the management of incidents and serious incidents stated that the effectiveness of this policy was monitored through an annual audit of 20 incidents from each division, to check compliance with the policy. This audit was to be led by the Patient Safety Manager and the outcome would be reported to the Quality and Patient Safety Group. The service did not provide us with evidence that an audit of incidents within the paediatric emergency department had taken place. This meant that the service could not provide assurances that all incidents reported on the incident reporting system had been graded correctly, all learning points identified, and measures put in place to reduce the likelihood of a similar incident happening again.

Engagement

Urgent and emergency services

Leaders actively and openly engaged with staff and patients to plan and manage services.

Key messages were communicated to staff in monthly Big 4 Safety Messages. The Big 4 Safety Message in April 2023 reminded staff that a failure to record information accurately in clinical records can result in reduced quality of care and actual harm to patients. We saw that these communications were used to remind staff of the paediatric resuscitation guidelines which stipulated that blood pressure must be completed manually if 2 consecutive high readings were obtained or if blood pressure was very low.

The Matron for Paediatrics had set up a team communications channel in April 2023 to coincide with the move into the new building. This provided a route for easy communication to all members of the children's emergency department nursing team. We saw the Big 4 Safety messages were communicated to all staff through this communications channel. Staff were also informed of any changes to process. We saw a communication which informed nursing staff that all ambulance handovers were to be taken by the nurse in charge for observations to be completed. This was a change in the usual process which had been implemented because of an incident. This message was posted on the communications channel and sent by email to all staff, to ensure everyone had received it. Changes were also discussed within staff huddles.

Prior to the development of the team communications channel, staff were kept updated on any changes through emails.

The service's Clinical Governance newsletter in August 2022 focused on learning from recent incidents and complaints. The newsletter stated that 'it is only by reporting incidents that we can learn from them and improve our service.'

Patients were encouraged to give feedback on the service both directly to the service through the Friends and Family Test or through a confidential service which was independent to Buckinghamshire Healthcare NHS Trust. We saw feedback from patients who had used the service between December 2022 and June 2023. Feedback was mostly complementary about staff. Examples of feedback included, 'Every member of staff was friendly, helpful and compassionate,' and 'both nurses and doctors were lovely despite how busy they were.' More recent complements were seen about the new building, including ''The new building was very nice, loved the solo room space and bathroom' and 'The new facilities are amazing, and it's made our journey much more comfortable as its peaceful and less chaotic.' Negative feedback included a theme around wait times and some people complained about having to be triaged in UTC before being sent to paediatric ED. Feedback was discussed within the SDU clinical governance meeting.

Formal complaints were directed to the Patient Advice and Liaison Service (PALS). We saw evidence of formal complaints from the paediatric emergency department being responded to by the Chief Medical Officer, the Chief Nurse and the Chief Executive of the trust following an investigation into the complaint. The responses included apologies and measures that had been put in place to reduce the risk of a recurrence. For example, the service had produced a patient advice leaflet to ensure that clinical staff gave consistent information following a complaint.

Areas for improvement

MUSTS

The trust must ensure there are effective systems and processes in place to ensure potential serious incidents have been correctly categorised, reviewed, thoroughly investigated and lessons shared to reduce the risk of reoccurrence. Regulation 17 (2).

Urgent and emergency services

SHOULDS

The trust should ensure that service users are aware that interpreters are readily available and that they are used when required and according to trust policy. Regulation 17

Our inspection team

We carried out an unannounced focused inspection of the paediatric emergency department at Stoke Mandeville Hospital. During the inspection visit, the inspection team:

- Inspected the new paediatric emergency department, children's observation unit, resuscitation room and urgent treatment centre (UTC).
- Looked at the triage process and patient journey from the UTC.
- Looked at a sample of 12 patient records.
- Observed the daily safety huddle.
- Spoke with 10 members of staff, including nursing staff, medical staff, and leaders of the service.

Following the inspection, the inspection team reviewed further service information such as policies, patient feedback, and training records.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance