

**Getting it right for children & young people  
(including those transitioning into adult services):  
a report on CQC's new approach to inspection**

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## 1. Introduction

- 1.1. In November 2013 you invited me to oversee work with the CQC to help ensure that the acute hospital inspection methodology that was being developed would be fit for purpose for specialist children's trusts. It was hugely encouraging both to me, and to other key stakeholders in the children's and young people's community, that you recognised the added complexities that the children's and young people's dimension would bring to the inspection process and that you were willing to give this particular consideration ahead of formally launching your programme.
- 1.2. As I mentioned to you when agreeing to lead this work, it did not make sense to consider the specialist children's trusts in isolation. We therefore agreed that I would offer advice on:
  - inspection of services for children & young people (CYP) within acute trusts, one of your identified core services, addressing general and emergency CYP services;
  - inspection of specialist children's services i.e. those provided by standalone specialist children's trusts and large tertiary children's services. **Annex A** sets out the providers that come under these categories.
- 1.3. In addition, it was agreed that I would make initial links to the developing inspection models for mental health, community and ambulance trusts as well as those in primary and social care to ensure that the needs of CYP are adequately considered and reflected as these models evolve.
- 1.4. I pulled together a small task & finish group including clinical experts and CQC colleagues to help me with this task (see **Annex B**). We adopted an inclusive approach to developing advice, consulting with key stakeholders at various stages including holding meetings with representatives from the standalone specialist children's trusts and the Royal College of Paediatrics & Child Health (RCPCH), having general communications with key individuals such as the National Clinical Director for Children, Young People & Transition to Adulthood, and arranging an initial scoping meeting with CQC and key outside stakeholders. This culminated in a number of engagement events:
  - a stakeholder event on 28 January 2014 for over 50 CQC and external stakeholders to seek input and views (see **Annex C** for external delegates);
  - three involvement events, two arranged by CQC and the other by the RCPCH to seek views directly from 29 CYP and 9 parents, carers and support workers (see **section 5** for more details).
- 1.5. In addition, I chaired an early Wave 2 inspection and all members of the task and finish group took part in at least one Wave 1 or Wave 2 inspection. This provided a useful opportunity to see how inspection of the CYP core service was working in practice and helped inform our thinking. We also discovered early on that there was a range of relevant work taking place within CQC to a variety of deadlines. Given a blank piece of paper, I would not have started from this point but I have had to be pragmatic, identifying and feeding into these programmes wherever possible rather than seeking to stop them and start from scratch. These work areas are referred to in the appropriate sections of this report.

- 1.6. This report sets out my advice. It is relevant to inspection of all services provided for CYP up to the age of 18 including their pathway through A&E, inpatient wards, surgery, outpatients and palliative & end of life care. It is also relevant to:
- the interface with maternity services - the maternity inspection sub-team in the acute model cover resuscitation of babies at birth and neonatal care as it relates to mothers. The CYP sub-team needs to cover neonatal services as they relate to babies. It will be important for the CYP and maternity inspection sub-teams to work closely to ensure neonatal services are adequately addressed during the inspection. In particular, they need to ensure that they consider what happens to the well babies that suddenly become sick;
  - transition to adult services – this has been an on-going concern for years and CQC’s themed inspection on children’s transition to adult services (focusing on young people with complex health needs), which is due to report shortly, looks likely to indicate that problems remain. Specific consideration of transition therefore needs to be considered by all sub-teams in the acute hospital inspection model (with the exception of maternity) and preferably commented on in their section of the trust report as well as being built into the other inspection models as they develop.
- 1.7. I have not addressed in detail the elements of an inspection that look at generic issues such as governance, risk management and complaints handling although I do make some references to these areas. These issues are already considered as part of the acute inspection model and should be built into the specialist children’s trust inspections as a matter of course.
- 1.8. I make a number of recommendations throughout the report. For ease, these are summarised after the conclusion. Some of these recommendations can, and should, be delivered immediately (i.e. for Q1 inspections) whilst others will need to be delivered in the medium to longer term. I strongly advised that CQC set actions in train now to enable delivery of these medium and longer term recommendations. I make a recommendation in **section 10** about the leadership needed to drive the CYP agenda forward within CQC and ensure these recommendations are met.
- 1.9. My overall remit was to advise on how the CQC could make its acute and specialist hospital inspection methodology fit for purpose for CYP and to make initial links with the other developing programmes. The pace at which CQC is having to deliver the acute hospital programme, and the differing timescales to which other models are working, has made this a challenge. However, I have achieved what was asked. I have produced a pragmatic rather than an aspirational report, focusing on what CQC can realistically be expected to deliver. I have also taken steps to enable CQC to pilot the modified methodology in two specialist children’s trusts in May. It will be important to learn the lessons from these pilots and enhance the methodology further if needed.

## 2. Background

### Key Points

- CYP are not '*little adults*' and should not be treated as such.
- It should not be assumed that CYP services are generally of a high quality. There is wide and unwarranted variation in service provision and care for CYP around the country.
- Recognition of the sick child, the deteriorating child and the maltreated child plus handover all along the pathway (including shared care arrangements) are key to delivering services for CYP that are safe, effective, caring, responsive and well-led and need to be considered as part of all CQC's inspection models.
- CQC must not lose sight of the overall pathway of care for CYP - the interface between its different inspection programmes will be key.

- 2.1. For this report, children and young people (CYP) are considered up to the age of 18. However, it should be noted that some services stop at 16 or other ages. Transition into adulthood and adult services is also important and cannot be neatly organised around a set age. Successful transition is dependent on the child's own transitional journey to adulthood which is impacted on by chronological age but also their sexual and emotional development.
- 2.2. CYP account for around 20% of the population in England and Wales and whilst they are common users of health services, for example, making up about a quarter of all emergency department attendances annually, their needs often get 'drowned out' by the wider workings of acute hospitals. Services for CYP often struggle to find a voice against other high profile services and political priorities which can impact on their development.
- 2.3. On 6 March 2014, the CQC published emerging findings from its 18 Wave 1 pilot acute hospital inspections. This indicated that services for CYP were generally of a high quality and one of the better performing core services. This finding should be viewed with caution as the ability of inspection teams to identify potential issues in these trusts would have been hampered by the paucity of information about CYP services in the pre-inspection datapacks (see **section 4**). There are in fact wide and unwarranted variations around the country in service provision and care for CYP. As the Report of the Children and Young People's Health Outcomes Forum in July 2012 highlighted this includes:
  - a 3 fold variation in admission of term babies into neonatal units;
  - a more than 4 fold variation in numbers of children attending emergency departments from equivalent general practices;
  - a 4–6 fold variation in admissions to hospital for bronchiolitis or asthma;
  - an 8 fold variation in expenditure on community children's services; and
  - a 3 fold variation in tonsillectomy rates.

2.4. The Forum also highlighted that:

- 26% of deaths showed '*identifiable failure in the child's direct care*';
- 43% of deaths had '*potentially avoidable factors*';
- approximately 75% of hospital admissions of children with asthma could have been prevented with better primary care;
- more than a third of short stay admissions in infants were for minor illnesses that could have been managed in the community;
- poor outcomes in long term conditions such as diabetes;
- concerns about services for children with disabilities or complex needs.

2.5. In addition, I would highlight that recognition of the sick child, the deteriorating child and the maltreated child, plus handover all along the pathway (including shared care arrangements), are all areas of continuing concern in CYP services. Addressing these areas will be key to delivering services for CYP that are safe, effective, caring, responsive and well-led in both acute and specialist trusts and need to be considered as part of CQC's inspection model.

2.6. CQC's new approach to inspection provides a real opportunity to drive up the standard of care for CYP across the country and reduce unacceptable variations. To do this CQC must get its inspection model right. It is imperative that the CQC does not just regard CYP as small people. Their health needs differ from adults and CQC needs to develop an understanding of the size and complexity of services for CYP and recognise that hospitals cannot be considered in isolation from community services, mental health service and primary care.

2.7. The CYP agenda can be considered in a number of ways, for example:

- by life stage (babies, toddlers, children, young people, transition to adulthood);
- by themes (child health, acutely sick, long term conditions, mental health etc);
- by settings (specialist children's trusts, acute trusts, mental health trusts, community; health services, primary and social care);
- by service (A&E, surgery etc).

2.8. As CQC has to inspect individual organisations and hold them to account, this report, and the recommendations within it, is mainly organised around the structure of the CQC inspection programme for the acute hospital:

- Pre-inspection preparation (intelligent monitoring and datapack);
- Site Visit (inspection team, where to go, who to speak to, what to ask, knowing what good looks like);
- Report & Quality Summit

2.9. This was a pragmatic decision to make it easier for CQC to consider and act on advice but it is important that the CQC does not lose sight of the overall patient pathway for CYP which does not sit neatly within one organisation. The interface between its different inspection programmes moving forward will therefore be key.

### 3. Overarching Acute & Specialist Hospital Inspection Model

#### Key Points

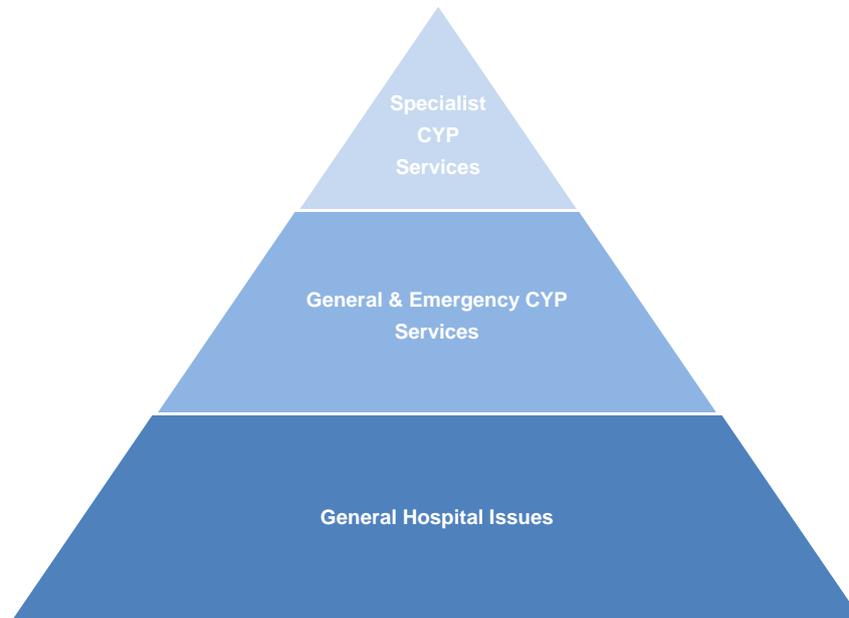
- The overarching model for acute hospital inspection provides a reasonable model for the inspection of services for children & young people (CYP) both in acute and specialist trusts.
- The inspection of CYP services can be considered in three parts: general hospital issues relevant to all acute & specialist hospitals; general & emergency CYP services relevant to all acute and specialist hospitals; and, issues specific to specialist CYP Services.

3.1. The overarching model for acute hospital inspection (preparation, site visit and report & quality summit) plus the general steps within each phase (surveillance, datapacks, listening events, key lines of enquiry, announced & unannounced visits, focus groups etc) provide a reasonable model for the inspection of services for children & young people (CYP) both in acute and specialist trusts.

3.2. The inspection of CYP services can be considered in three parts:

- general hospital issues that need to be covered as part of any acute or specialist hospital inspection irrespective of the service being considered. This covers issues such as staffing (e.g. numbers, skill mix, mandatory training) , environment (e.g. maintaining equipment, cleanliness and infection control) and learning from experience ( e.g. SUI reporting). Whilst the issues are not specific to CYP services, CYP specific prompts are useful to ensure that the inspection team understand the impact of these issues for CYP services (see **Annex G**);
- general & emergency CYP service issues – these are issues that are specific to the core service identified for the acute model but are relevant to both acute and specialist trusts, for example, paediatric specific equipment available in theatres (particularly shared theatres in acute trusts);
- specialist CYP service issues – these are issues that are relevant to the standalone children’s specialist trusts and large tertiary children’s service, for example, compliance with national specialised service specifications.

This is illustrated in the following diagram:



- 3.3. This report covers all three parts but the general hospital and the general & emergency CYP service issues are considered together as part of advice on the acute model. Where issues are only relevant to specialist services this is flagged.

## 4. Pre-Hospital Inspection Preparation

### Key Points

- Absence of data related to services for children & young people (CYP) remains a problem.
- The ability of inspection teams to identify potential issues in CYP services is hampered by the paucity of information about CYP services in the datapacks.
- CQC needs to make better use of the data already available and work with stakeholders to improve what is available in the longer term. CQC should not underestimate the leverage it currently has to improve this situation and the impact this will have on the effectiveness of its inspections.
- Data is only part of the story – it should not be over relied on or over interpreted.
- CQC should not underestimate the power of qualitative information to flag issues to consider during inspection. Feedback needs to be proactively sought from key stakeholders and considered ahead of inspections.
- The CQC intelligence directorate must continue its dialogue with specialist children’s services to ensure that the Intelligent Monitoring Tool is more robust for CYP services than at present.

- 4.1. There is consensus amongst the children and young people’s (CYP) community within our country and other countries, borne out at the stakeholder event on 28<sup>th</sup> January, that there has been and continues to be a paucity of data in relation to CYP services. This will need to be addressed if the CQC is to reliably identify those trusts that may be a high risk in terms of CYP services and if inspection teams are to be well-informed ahead of site visits.
- 4.2. This section sets out advice to strengthen pre-hospital inspection preparation as it relates to services for CYP. It takes into account views expressed at the stakeholder event on 28 January (see **Annex C**) along with discussions between the task and finish group, members of the CQC Strategy & Intelligence Directorate and consultants from PwC working for CQC on datapacks and workbooks. It covers outcomes and indicators (including patient experience) that should be built into CQC’s surveillance and inspection programme and general developments needed to the intelligent monitoring tool (IMT) and the datapack.

### Outcomes & Indicators (incl patient experience)

- 4.3. Improving the range of data that is available to, and used by, CQC is key and CQC should put its weight behind implementation of the CYP’s Health Outcomes Forum’s recommendations for outcomes and indicators submitted to the Department of Health in July 2012. Provision of data related to CYP services has failed to progress over a number of years and CQC should not underestimate the leverage it currently has to improve this situation and the impact this will have on the effectiveness of its inspections.

- 4.4. A subset of the Forum's recommended outcomes and indicators will be of particular use to CQC as part of its surveillance and inspection programme – this subset is set out at **Annex D** and I recommend that these outcomes and indicators are incorporated into the intelligent monitoring tool and/or datapack as appropriate as soon as possible. For a number of these indicators, data is already available (although in some cases definitions need development). For others, a new data source or adaptation to an existing data source will be needed and CQC will need to work with stakeholders such as DH and NHS England to ensure that momentum is maintained for the development of these outcomes/indicators.
- 4.5. There has been a long standing inequity between information on patient experience available about adult and CYP services. It is therefore good news that CQC is funding the development of an inpatient survey for CYP and parents. I understand that, subject to receiving the necessary data collection approvals, there will be three surveys aimed at:
- 0-7s: to be completed by parents/carers;
  - 8-12s: a short section for children to complete directly and a separate questionnaire/ section for the parent/carer;
  - 13-17s: a short section for young people to complete directly, and a separate questionnaire/ section for the parent/carer.
- 4.6. The current plan is to run these surveys from August to December 2014 and I recommend that the results are built into the Intelligent Monitoring Tool and the datapacks as soon as they are available. I also recommend that CQC funds this as an annual survey.

#### **Developments to the intelligent monitoring tool (IMT)**

- 4.7. The aim of the CQC intelligent monitoring tool (IMT) is to provide an assessment of risk within a trust in terms of whether it is safe, effective, caring, responsive and well-led based on more than 150 different indicators. This helps CQC to prioritise its inspection programme i.e. when, where and what to inspect.
- 4.8. The first iteration of the IMT only had one tier 1 indicator with a direct relationship to CYP services (composite indicator: in-hospital mortality - paediatric & congenital disorders and perinatal mortality) plus one indirectly related indicator (maternity outlier alert: maternal readmissions). This made it impossible to identify if there were problems with CYP services in an acute trust against the '*adult noise*'. In addition, for the standalone specialist children's hospitals where less than a third of the indicators are applicable, there are legitimate concerns about how weighting of individual indicators might skew a specialist children's trust's risk score when compared to acute trusts.
- 4.9. It is recognised that CQC has to start somewhere and if we wait for a perfect model we will be unlikely to publish anything. It is also recognised that the IMT is supposed to flag up issues for further consideration rather than provide judgements. However, CQC must be alert to the damage that a high risk banding can have to a trust in terms of patient and parent confidence and staff morale as well as the reputational risk to CQC if the IMT does not flag risks due to lack of appropriate data. It is recommended that the intelligence directorate continues its dialogue with specialist children's services to ensure that the IMT is more robust in terms of consideration of CYP services than is currently the case.

- 4.10. I have already recommended that the surveillance team work as a matter of priority to build the indicators and outcomes listed at **Annex D** into the IMT (see **para 4.4**). Where these indicators/outcomes are not appropriate for use in the IMT (as either tier 1 or tier 2 indicators) then it is recommended that they are included within the CYP datapack as a minimum to inform key lines of enquiry (KLOEs).
- 4.11. Whilst this work is on-going, it is recommended that the IMT includes a breakdown of the current indicator collection by age where this is possible and the CYP data is shown separately. In terms of the age bands for indicators, as a minimum this should be presented for the 0-17 age range but ideally should be presented across three age bands (0-1, 1-17, 18-25). This should be possible for indicators based on HES data and CQC needs to bring pressure to bear to facilitate the provision of other data sources by age. In the longer term, I recommend that CQC should work towards an age breakdown for all data sources in 5 year bands to improve comparisons with other countries.
- 4.12. It is accepted that there may be limitations to the number of additional indicators that can be included within the IMT (at least in the short term) and, that being the case, I recommend that the following are prioritised for inclusion:
- CYP/parent/staff confidence in CYP services (i.e. from Friends and Family Test and staff surveys)<sup>1</sup>;
  - existing mortality indicators by age<sup>2</sup>;
  - never events involving CYP;
  - SUIs involving CYP<sup>3</sup>;
  - NRLS data<sup>4</sup> ;
  - Nurse sickness, turnover, stability (as indicators of staff satisfaction);
  - Agency rates.

Notes:

1. This is probably better than any low number outcome statistic at present and if there are concerns about the national data then the onus needs to be placed on trusts to do these surveys more effectively rather than dismissing this as unfeasible for CYP.
2. It is not yet clear whether looking at existing mortality indicators by age will have sufficient 'signal to noise' ratio to allow detection of outliers or even if it is a useful indicator for CYP services. It is key that CQC analysts test this. In the longer term the National Clinical Director for Children, Young People and Transition to Adulthood is working with the Specialist Children's Hospitals to pilot a standard child mortality pathway, from moment of death to report to local Child Death Overview Panel (CDOP). If this is successful it should be rolled out to all inpatient children's units. This, alongside work on CDOP more generally (see **para 4.23**), could result in more standardised collection and reporting of child death data and process. CQC needs to keep abreast of these developments.
3. Serious Untoward Incident (SUIs) should include serious case reviews (SCRs), failure to recognise illness and/or unexpected deterioration resulting in cardiac or respiratory arrest, Paediatric Intensive Care (PIC) admission or death, medication errors resulting in significant harm and tenfold prescribing or drug administration errors. The Forum's proposed '*failure to monitor*' indicator (see **Annex D**) should be incorporated once developed.
4. NRLS data should be used as an indicator of patient safety reporting and safety culture for CYP services in acute trusts (i.e. to identify trusts that are under-reporting compared to peers or have patterns of incident types that differ substantially from peers). It should be used within the IMT to compare specialist children's trusts and larger children's tertiary providers against each other but not against other acute trusts. The small number in the peer group may mean there are rarely any significant differences detected but this does not mean it is an option that should be rejected. In addition, due to the small numbers the NRLS data on CYP could be used descriptively in inspection packs i.e. brief summaries of incidents of moderate harm or above to inform key lines of enquiry.

## General developments needed to the datapack

- 4.13. Whilst the IMT is clearly important as a means to monitor trusts and help prioritise the inspection programme, there are limitations to the data related to CYP that can be meaningfully included, at least in the short term, in this tool. The datapack is therefore the area where the biggest difference could be made to provide a rounded picture of a trust's CYP service in the short term. There is real potential to inform the inspection, identifying areas where inspectors need to focus and thus increase the chance they have to highlight areas of concern that could be masked at present as well as areas of good practice.
- 4.14. On 6 March 2014, the CQC published emerging findings from the 18 Wave 1 pilot hospital inspections that took place from Sept-Dec 2013. It noted that services for CYP were generally of a high quality and one of the better performing core services. This finding should be viewed with caution. The datapacks that were used for the Wave 1 pilots included very little information related to CYP services. In fact, it is fair to say, that it would have been hard to tell that an acute trust provided a CYP service on the basis of these packs. Without an informative datapack, the ability of an inspection team to identify potential issues that needed further consideration is hampered and any judgement/rating of a CYP service has to be based almost entirely on the physical inspection unsupported by data.
- 4.15. I would have recommended that the CYP element of the inspection datapacks needed to be significantly enhanced. However, the on-going evaluation during Wave 1 enabled this to be identified as an issue early on and work is already in hand to produce a datapack/workbook focused on CYP services. This is welcome news and I have taken early steps to inform the content of this datapack/workbook.
- 4.16. There is still more to do and **Annex E** sets out (according to CQC's 5 domains) both quantitative and qualitative information that needs to be included in the datapack to support inspection of CYP services. Some of this is data that is available from national sources. Some will need, at least in the short term, to be requested from the trust itself, and some will need to be requested from stakeholders. In some cases, stakeholders may not have immediate access to this information. However, if CQC starts to ask organisations for the right information now it will point them to what they need to know. CQC can therefore act as a powerful lever for improvement both directly and indirectly. I recommend that the CYP datapack is based on the data set out in **Annex E** building in information from **Annex D** (the outcomes and indicators recommended by the Forum) as they become available.
- 4.17. Presentation of quantitative information within the datapack will be important. The inspection team needs to understand and use the information presented to best effect. I therefore recommend that CQC works with the '*organisers*' of all audits it uses to identify an '*accepted*' range/means to detect outliers for indicators. CQC will need to ask trusts to provide their own data to compare to the nationally provided range/benchmark where this is not automatically in the public domain. The Healthcare Quality Improvement Partnership (HQIP) provides public access to a considerable amount of its national audits. The inclusion of audit data within CQC datapacks was strongly supported by stakeholders we consulted (including senior representatives from professional bodies) so it is expected that CQC will be supported in this task. Summaries of findings from the latest CYP peer reviews e.g. child & adolescent cancer services and paediatric diabetes also need to be included – they are an important element of quality improvement.

- 4.18. In an ideal world, there would be an overarching clinical dashboard for CYP services akin to the maternity dashboard produced by the Royal College of Obstetricians and Gynaecologists. However, this is not realistic in the short term for CYP services given the range of conditions that would need to be covered. Whilst dashboards for some subsets of the CYP service are available or in development, if CQC wishes to use an overarching clinical dashboard for CYP services I recommend that it commissions a piece of work to produce this in collaboration with key professional bodies.
- 4.19. Whilst quantitative data is vital to support inspections, CQC should not underestimate the power of qualitative information to flag issues that may be worthy of additional consideration during inspection. It is therefore recommended that a range of information is sought from key stakeholders ahead of the inspection and summarised for inclusion in the datapacks so that the chair and inspection team have an opportunity to consider this information ahead of the inspection and use it to inform the inspection.

*Information to request from the trust*

- 4.20. I recommend that the following should be requested from the trust (if not available from another source) to inform the inspection:
- summary of complaints/PALs data relating to CYP services [**acute & specialist trusts\***]
  - specialised paediatric health services and/or specialised services which cover both adults and children provided [**specialist trusts only**]
  - top 5 referring trusts/DGHs by volume of patients referred [**specialist trusts only**]
  - any trusts (other than those identified as top referrers) where there are significant shared care/network arrangements [**specialist trusts only**]
  - top 5 clinical commissioning groups by volume [**specialist trusts only**]
  - satellite and/or outreach services provided including locations, clinical accountability and governance arrangements and a brief summary of how quality in these services is assured including an example of data used for internal QA purposes? [**acute & specialist trusts only**]
  - local CAMHS provider(s) [**acute & specialist trusts**]
- \*Note:  
Specialist trust in this context refer to the standalone specialist children's trusts plus large tertiary children's services as set out at **Annex A**.

*Information to request from key service stakeholders*

- 4.21. I recommend that the following key service stakeholders should be asked what works well and what works less well in their relationship with the specialist trusts/large tertiary providers. In particular:

- top 5 referring trusts/DGHs should be asked for feedback on issues such as:
  - how easy is it to get specialist advice in and out of hours;
  - how easy is it to get their CYP seen by the tertiary provider;
  - what discharge information and support they receive when CYP are discharged back to their care and if they think this is adequate for their needs etc;
  - support for secondary care staff to develop specialist competencies as appropriate?
- trusts (other than those identified as top referrers) where there are significant shared care/network arrangements should be asked for:
  - feedback on how well shared care is working in practice; and,
  - any concerns they have.
- NHS England should be asked:
  - for evidence that there is compliance with relevant National Specialised Service Specifications, any derogations from these specifications, action they are taking as a result including timescales until expected compliance, and how confident they are in these services.
  - based on the 6 monthly audit information or any other intelligence they have, if they have concerns about any of the nationally commissioned services at the trust and if so, what action they are taking.
- top 5 clinical commissioning groups should be asked for feedback on what is working well and less well at the trust.
- hosts of satellite and/or outreach services (or a sample) should be asked for feedback on what is working well and also any concerns about the quality of the service provided.

4.22. In addition, I recommend that it would be useful to ask the local CAMHS for all acute and specialist trusts for feedback on how well patient pathways are working for those CYP with emotional and mental health problems.

*Information to request from other stakeholders*

4.23. I recommend that feedback should also be sought about acute and specialist trusts from:

- the Royal College of Paediatrics & Child Health (RCPCH) – in addition to RCPCH audit data and information related to training assessments, the RCPCH should be asked if they have carried out an invited review at the trust or have been alerted to any key concerns by members;
- the Royal College of Nursing (RCN) should be asked if they have been alerted to any key concerns by members etc. It should be noted that CQC letters to stakeholders currently go to the Chief Executive or equivalent and are copied to a relevant general contact. The RCN Adviser in Children and Young People's Nursing needs to be copied in to this correspondence to ensure feedback relevant to CYP services is provided where appropriate;
- The Royal College of Surgeons (RCS) should be asked if they have carried out an invited review at the trust or have been alerted to any key concerns by members;

- Child Death Overview Panel (CDOP) – over 90% of child deaths occur in a hospital setting so, in the short term, the local CDOP should be asked if they are aware of any deaths in relation to the hospital about to be inspected. In the longer term, NHS England is leading work to improve use of evidence received by CDOPs including an 18 month development project to create a National CDOP Database. CQC needs to keep abreast of these developments.
- CQC’s Children’s Services Inspection Team – should be asked if there is any feedback for recent reviews.

## Other Developments

4.24. It should also be noted that:

- the Children's Intelligence Network (modelled on National Cancer Intelligence Network) should provide a useful source of data for the future;
- work is progressing within NHS England on the development of a National Paediatric Safety Thermometer with a test data collection due to start from April 2014. When a final version is available, information from this tool should be incorporated into the inspection datapacks. CQC will need to liaise with NHS England about appropriate presentation and commentary.

### Summary of Recommendations

#### *Short term*

- The IMT should include a breakdown of the current indicator collection by age showing CYP data separately in age bands (0-1, 1-17, 18-25).
- A CYP specific supplement to the inspection datapack is needed based on quantitative and qualitative information set out in **Annex E**.
- Feedback should be sought from a range of stakeholders and built into the datapack so that the chair and inspection team have an opportunity to consider this information ahead of the inspection and use it to inform the inspection. These stakeholders should be asked for feedback on specific issues as set out in **para 4.21**.

#### *Medium term*

- The following indicators should be prioritised for inclusion within the IMT for CYP: CYP/parent/staff confidence in CYP services; existing mortality indicators by age; never events involving CYP; SUIs (including SCRs) involving CYP; NRLS data; nurse sickness, turnover and stability rates; and agency rates.
- CQC’s surveillance team should build the subset of the CYP’s Health Outcomes Forum’s indicators and outcomes identified in **Annex D** into the IMT as a matter of priority. Where these indicators/outcomes are not appropriate for use in the IMT (as either tier 1 or tier 2 indicators) then they should be included within the CYP datapack as a minimum to inform key lines of enquiry (KLOEs).
- The results of the new CYP inpatient survey should be built into the IMT and datapack once available.

- CQC should work with the '*organisers*' of all audits it uses to identify an '*accepted*' range/benchmarks (if there is not one set already) to help inspectors identify potential outliers etc and includes this in the IMT and/or datapack.

*Longer term*

- CQC should work with stakeholders to develop the indicators/outcomes recommended by the Forum that need a new data source or adaptation to an existing data source.
- CQC should fund the inpatient survey for CYP and parents as an annual survey.
- CQC should use 5 year age bands for data.
- Intelligence directorate should continue its dialogue with specialist children's services to ensure that the IMT is more robust in terms of consideration of CYP services than is currently the case.
- If CQC wishes to use an overarching clinical dashboard for CYP services, it should commission a piece of work to produce this in collaboration with key professional bodies.

## 5. Involvement of Children, Young People & Parents

### Key points

- The views of children & young people are fundamentally important. How to get those views is a challenge if it is not to be tokenistic. Robust and realistic methodologies still need to be developed.
- CQC hospital inspections take place during term time. Children should not be taken out of school to be involved in the inspection process. Children who have experienced prolonged periods of ill health may already have missed many days of schooling and should not be encouraged to miss more. The focus should be on seeking views from CYP and parents who are in the hospital during the inspection period.
- CQC should involve parents in the inspection process setting up a new cohort of experts by experience that are parents of children that have used health services (including, but not restricted to, parents of children with long term conditions and/or complex needs).
- Young adults who have experience of health services could be encouraged to take part in the inspection process.
- CQC should consider using mobile technology to encourage feedback from CYP using services.

- 5.1. The Health and Social Care Act 2012 acknowledges that organisations such as the CQC should involve patients, carers and the public in the inspection and regulation of health and social services. It is clear that the views of CYP and parents need to be heard and taken into account as part of CQC inspections. How to get the views of children in particular is a challenge and robust and realistic methodologies still need to be developed.
- 5.2. We have involved CYP and parents to advise on what a good CYP service looks like from their perspective so that we could feed that into our thinking as we developed recommendations for what the inspection needs to consider. Three focus groups were held as part of this. The first consisted of fourteen CYP aged 10 to 22 who were members of the CQC Youth Advisory Panel and had long term conditions or complex needs. The second sought the views of five parents and carers and four support workers. The third consisted of fifteen CYP aged 14 to 26 who were members of the Royal College of Paediatrics and Child Health Youth Advisory Panel. The views on '*what good looks like*' from the perspective of CYP and parents is set out at **Annex F** and has been factored into my thinking.
- 5.3. In addition, at the January stakeholder event (see **Annex C**), we explored two key issues:
- how best to get the views of CYP and parents who use/have used the hospital services being inspected;
  - involving CYP and parents in the inspection process itself i.e. on inspection teams.

The remainder of this section sets out advice on these two areas.

## Getting the views of CYP and parents who use/have used the services being inspected

5.4. The views of both CYP and parents who use/have used the service need to be taken into account during an inspection. Options that have been considered include holding:

- specific focus groups for CYP (ad-hoc users of health services as well as those with long term conditions across all age groups) with facilitated discussions in advance of the CQC inspection at a time that does not disrupt schooling. The CQC piloted such a focus group comprising of 20 CYP from 7 different youth groups from East Kent prior to an acute trust inspection. This event allowed young people to express their views on both CQC and on the local services they had received.
- listening events (akin to those held for acute inspections) aimed at CYP and their parents and carers at times appropriate for school-aged children and young people to attend to share their personal experiences of care at the trust, both positive and negative.

5.5. I am not convinced of the value of dedicated events for CYP ahead of an acute hospital inspection. Whilst CQC may wish to test this concept further, I would recommend that for acute and specialist trust inspections, CQC should focus on:

- analysing a sample of complaints from the previous 3-6 months related to CYP services at the trust;
- ensuring publicity for the existing listening events emphasises that parents are welcome to attend to share the experiences of their children at the trust;
- developing more social media friendly listening events for the longer term which might be more appealing to young adults;
- interviewing both CYP and parents who are on wards, attending outpatient clinics and at A&E during the inspections to gather views – these interviews should be conducted by members of the inspection team specifically allocated to inspecting services for CYP. Eventually, this task could be carried out by parental experts-by-experience;
- asking trusts as part of the KLOEs how they seek inpatient feedback from CYP using modern technologies (e.g. Fabio the Frog or equivalent);
- funding an annual in-patient questionnaire for CYP and parents (see **para 4.6**);
- enhancing its profile through social media used by CYP and encouraging feedback using mobile technologies.

5.6. For specialist children's hospitals/large tertiary providers, I recommend that there should also be:

- listening event(s) aimed specifically at parents and carers;
- a focus group outside of school time arranged with members of the children's council (or equivalent) run by a facilitator trained in working with CYP.

## Involving CYP and parents in the inspection process

5.7. A significant proportion of the stakeholders we spoke to advised that CYP should be involved in the inspection process itself i.e. part of the inspection teams. They advised that CQC should engage with local and national bodies and publicise opportunities through avenues such as hospital children networks, Patient Advice and Liaison Service within hospitals, local schools, youth groups, after school clubs, youth parliaments, local health watch and regional voices to ensure there is adequate representation of CYP on inspections.

5.8. I have considered these opinions. However, I am strongly of the view that school aged children should not be involved in the inspection process itself. Whilst this could be a long term aspiration, I believe it is impractical and undesirable at the present time. CQC inspections take place during term time and CYP should not be taken out of school to be involved in this process. This is particularly important for CYP who have experienced prolonged periods of ill health and may already have missed many days of schooling. I have considered other options such as ‘hospital tours’ at weekends but I remain to be convinced of the value they would add. I therefore recommend that the focus should be on:

- introducing parents as a specific cohort of ‘experts by experience’ as part of CQC’s Experts by Experience programme and encouraging them to participate in inspections. This should include parents of any child that has used health services not just parents of children with long term conditions. The CQC involvement team should explore this further with organisations such as the National Network Parent Carer Forum. Short break care to enable a parent with current caring duties to take part in an inspection would need to be considered.
- inclusion of parents in all acute and specialist trusts inspections if possible but, as an absolute minimum, at least 2 (preferably 4) parents on the inspection team of specialist children’s trusts and large tertiary providers. This should include at least one parent of a child with a long term condition or disability, preferably with some experience of using a tertiary provider. These parents should receive adequate training and support and lead interviews with CYP and parents in the hospital on the day of the inspection.
- encouraging young adults (19 and over) to take part in inspections, particularly those who experienced hospital services when younger. However, we need to recognise that this might not be an attractive proposition for large numbers of working age adults.
- ensuring that Healthwatch has the capacity to strengthen the voice parents and CYP. In the short term the focus should be on the parent voice and should include, for example, arranging some bespoke engagement activities for parents ahead of inspection of specialist children’s trusts or large tertiary children’s services. Local healthwatch also have an important role to play in ensuring that a trust’s action plan following an inspection is implemented.

## Summary of Recommendations

### *Short term*

- Include parents in all acute and specialist trusts inspections if possible but, as an absolute minimum, include at least 2 (preferably 4) parents on the inspection team of specialist children's trusts and large tertiary providers.
- Analyse a sample of complaints from the previous 3-6 months related to CYP services at the trust.
- Ensure publicity for the existing acute trust listening events emphasise that parents are welcome.
- Interview CYP and parents who are on wards, attending outpatient clinics and at A&E during the inspections – these interviews should be conducted by members of the inspection team allocated to inspecting services for CYP.
- Ask trusts as part of the KLOEs if and how they use modern technologies to seek inpatient feedback from CYP.
- Hold a listening event aimed specifically at parents and carers [**specialist children's hospitals/large tertiary providers only**].
- Hold a focus group (outside of school time) with members of the children's council (or equivalent) [**specialist children's hospitals/large tertiary providers only**].
- Arrange a bespoke engagement activity for parents ahead of inspection of the 2 specialist children's trusts pilots. [**specialist children's hospitals only in the first instance**].

### *Medium term*

- Introduce parents as a specific cohort of the 'experts by experience' programme.
- Train parental experts-by-experience to interview CYP and parents during inspections.
- Enhance CQC's profile through social media such as YouTube, Facebook and Twitter.
- Encourage young adults (19 and over) to take part in inspections.
- Work with Healthwatch to strengthen the voice parents and CYP.

### *Longer term*

- Develop more social media friendly listening events which might be more appealing to young adults.
- Fund an annual in-patient questionnaire for CYP and parents.
- Encourage feedback from CYP using mobile technologies.

## 6. Site Visit

### Key Points

- It is encouraging that CQC has identified services for children & young people (CYP) as a core service for inspection of acute trusts.
- Having appropriate expertise on the inspection teams will be key to the success of the CQC inspections – ‘adult only’ clinicians are not an appropriate substitute for experts in CYP services on acute hospital inspections.
- Inspection of CYP services in acute trusts should not be considered quorate without a children’s nurse and a doctor who has completed training in paediatrics on the team – without both these experts it is not possible to reliably rate a CYP service. Inspection of specialist trusts will need considerably bigger teams of experts.
- Parents need to be included as ‘*experts by experience*’ on inspection teams, particularly for the specialist children’s hospitals and large tertiary providers.
- It will not be feasible to visit every area where CYP will be seen and treated. There are some areas that should always be inspected and some where a sample of areas will need to suffice. The format of the visit will need to be flexible informed by datapacks, feedback from stakeholders, staff focus groups, listening events and observations.
- CYP services will always need to be visited at night either as part of the announced or unannounced inspection.
- During an acute inspection, the other core service sub teams may need to consider some CYP issues - this will need to be agreed between the teams at the start of the inspection. As a minimum all acute sub-teams (except maternity) should ask about transition to adult services.
- To support consistent judgements it will be important for inspection teams to have a shared view of ‘*what good looks like*’ for CYP services in acute trusts. It will not be feasible for CQC to consider services against all national guidance, standards and audits so key guidance and indicators along with observations should be used as a proxy to judge whether CYP services (general or specialist) are good.

6.1. This section focuses on getting the most from the acute hospital site visit when inspecting the CYP core service. It covers:

- having the right inspection team;
- inspecting the right places;
- speaking to the right people;
- asking the right questions;
- knowing what good looks like.

- 6.2. This advice is based on feedback from the stakeholder event on 28 January (see **Annex C**) and communications from stakeholders who were not able to attend the event. The advice is equally applicable to CYP services within specialist children's trusts and large tertiary services. Where differences/ additions are suggested for specialist providers these are flagged. In addition, **section 7** focuses specifically on the modifications needed to the process for specialist children's trusts and large tertiary providers.
- 6.3. Due to the timescales CQC has been working to for the inspection of acute trusts, some of the advice in this section has already been fed through to the Strategy & Intelligence Directorate to inform guidance that they have been producing to support teams taking part in Wave 2 pilots and the inspections scheduled for Q1. If this advice has not already been incorporated then it should be.

## Overview

- 6.4. It is very encouraging that CQC has identified services for CYP as a core service for inspection of acute trusts and I accept the decision to consider these services as a whole i.e. from A&E to palliative and end of life care rather than as part of each individual core service. Having said that, for the inspection of acute trusts it will not necessarily be feasible for the CYP 'sub team' to inspect all aspects of this pathway. It will therefore be important for the CYP team to communicate with the other core service sub teams to ensure a shared understanding of which sub-team will be focusing on what at a given inspection and to ensure that the adult focused teams consider services through a CYP lens where that is needed (with appropriate advice and support) particularly in relation to transition. A flexible approach will be needed on each inspection.

## Who should be on the inspection team

- 6.5. Having appropriate expertise on the inspection teams will be key to the success of any CQC inspection. It is particularly important that CQC recognise that 'adult only' clinicians are not an appropriate substitute to a children's nurse or paediatrician when considering CYP services.

### Acute trusts

- 6.6. The acute inspection team should always include the following clinical experts:

- a consultant paediatrician or a doctor who has completed training in paediatrics; and,
- a children's nurse.

Whilst we need to be realistic in terms of requirements for inspection team membership, it is impossible to carry out a meaningful and credible inspection of CYP services without both these experts represented. I recommend that an inspection team is not quorate and should therefore be unable to rate a CYP service in the absence of both these experts.

- 6.7. In addition, I recommend that, if possible, the parent of a child that has used health services is included within the acute hospital inspection team. Short break care to enable a parent with current caring duties to take part in an inspection would need to be considered. If 'experts by experience' with a non-CYP background are included in the CYP sub-team, for example, to speak to parents, it should be noted that they may find it a challenging environment,

particularly intensive care or palliative care settings, and additional support may need to be offered.

- 6.8. It is noted that a pharmacist will generally be included as part of the inspection team for acute trusts. I recommend that the pharmacist should ask specific questions in relation to medicines managements in relation to CYP. Prompts have been built into appropriate KLOEs to address this at **Annex G**.
- 6.9. It is highly desirable that the CYP sub team leader on an acute inspection has some background knowledge and experience of inspecting CYP services. I recommend that the CQC Academy introduces a programme to develop sufficient numbers of CQC inspectors in this area.

#### *Specialist children's hospitals/large tertiary providers*

- 6.10. When inspecting a specialist children's hospital/large tertiary providers, the inspection team needs to include the following clinical experts:

- consultant paediatrician or a doctor who has completed training in paediatrics
- paediatric surgeon\* (any speciality unless a particular issue has been identified ahead of inspection)
- paediatric anaesthetist\*
- paediatric intensivist
- specialist paediatrician (discipline is not key unless a particular issue has been identified ahead of the inspection. They bring an understanding of how CYP tertiary services work, the relationships with secondary care providers, networking and shared care etc)
- paediatric A&E clinician (for trusts with an A&E department)
- trainee in paediatrics
- children's nurse
- specialist children's nurse (to bring an understanding of how CYP tertiary services work rather than particular clinical expertise)
- children's theatre or recovery nurse\*
- a student nurse working in CYP services
- an AHP with experience working with CYP
- a hospital play specialist (subject to results of pilot inspections)
- a paediatric pharmacist
- a paediatric general manager

*Note: if the team becomes too large and/or if there is trouble recruiting to a particular inspection, it is imperative that the team includes at least one person who understands theatres in relation to CYP ( i.e. surgeon/ anaesthetist / theatre or recovery nurse).*

It might also be necessary to include:

- a clinician with specific expertise in palliative and end of life care for CYP if this expertise is not available from any of the above clinicians
- a neonatologist or neonatal nurse if there are specific issues with the neonatal service;
- an executive/clinical director from a CYP service
- specific experts in response to concerns identified ahead of, or during the inspection.

6.11. In addition, I recommend that at least two (preferably four) parents of children who have experience of hospital services (at least one tertiary if possible) are included on the inspection team. This should include at least one parent of a child with a long term condition or disability. I also recommend that young people (over 19s) with experience of using hospital services should be encouraged to take part in inspections but I am not convinced that this will be an attractive proposition for large numbers of young working age adults.

### **Where to inspect**

6.12. The inspection team should be provided with a list of all areas in the hospital where children and young people (CYP) might be seen and treated. Some of these will be CYP specific areas, some areas where both CYP and adults are seen and treated and some may be predominantly adult environments where CYP might be seen on occasion.

6.13. If time allows, an initial walkabout of as many areas as possible should take place to provide an overarching sense of the CYP service.

6.14. It will not be feasible to visit every area where CYP will be seen and treated. There are some areas that should always be inspected and some where a sample of areas will need to suffice. The format of the visit will need to be flexible with areas for focused inspection identified from the list of areas where CYP are seen supported by observations from the general walkabout (if one takes place), and the data/surveillance provided in datapacks and feedback from stakeholders, focus groups and listening events etc.

6.15. As previously mentioned, it will be necessary for the CYP team to consider how it works with the other core service teams to ensure that certain issues related to CYP are addressed by other teams (e.g. by A&E, outpatient and surgery teams) when necessary and appropriate, for example where young people are seen in predominantly adult areas and in relation to transition to adult services.

6.16. I recommend that the following areas should be inspected as part of CYP services:

- **Children's A&E** – the CYP team will need to liaise with the A&E team on the best approach including how CYP (particularly young people) are dealt with if they present to/have to be seen in adult A&E. This will be reported as part of the A&E service report (see **section 8**);
- **Children's assessment unit**;
- **Children's inpatient wards** (sample only);
- **Children's surgery (anaesthetic room, theatre & recovery)** – the CYP team will need to liaise with the surgery team to see who is best placed to consider areas where both adults and CYP are seen;
- **Children's outpatients** (sample only) – the CYP team will need to liaise with the outpatient team to consider how to cover areas where both adults and CYP will be seen;

- **Neonatal Unit, Special Care Bay Unit (SCBU)** – the maternity team in the acute model covers resuscitation of babies at birth and neonatal care as it relates to mothers. The CYP sub-team covers neonatal services as it relate to babies. It will be important for the CYP and maternity inspection sub-teams to work closely to ensure neonatal services are adequately addressed during the inspection. In particular, they need to agree how the quality of services for well babies who become sick will be inspected;
  - **Paediatric Intensive Care Unit (PICU)**
  - **Palliative & End of life Care** - the CYP team will need to liaise with the EOLC team to consider how this area is best inspected for CYP needing palliative or end of life care;
  - **Transition Services** (transition clinics, adolescent wards and spaces dedicated to adolescents and young people). In addition, all core service sub teams need to ask how adult services manage young people moving to them see **Annex G R1**;
  - **Selection of areas which are not specific to CYP** (and are not covered by any of the above) including: imaging (particularly x-ray and CT); day case; and sexual health services where under 16s attend;
  - **'8 til late' and 'short stay units'** including those provided by the trust on different sites;
  - **Hospital Play Service;**
  - **Facilities for Parents.**
- 6.17. Thought needs to be given to the timing of certain elements of the CYP sub team visits in order to gain maximum information and insight. For example, patient flow is often identified as a problem in services for CYP. This could be identified, for example, by visiting the day surgery unit at 8am to see if admissions overnight are impacting on the morning intake. It is also important to get a sense of how care is delivered at night when many parents have gone home and there are more lone children. If this cannot be scheduled during the announced visit then it is recommended that inspection of CYP services should always be part of the out of hours unannounced inspection.
- 6.18. It is recommended that case note tracking should be used during the inspection to follow the pathways of a number of CYP during the inspection period including consideration of the quality of documentation and the views and experiences of parents and the CYP themselves for those whose cases are being considered. This should give an indication of how different CYP services interact.
- 6.19. If there are any concerns identified about the quality of satellite and/or outreach services provided by specialist trusts or large tertiary providers as part of the pre-inspection information gathering then I recommend that a visit to a sample of these services may need to be arranged.
- 6.20. Education is important for CYP spending long and/or repeated periods in hospital. The hospital school will be registered with OFSTED and does not need to be visited as part of this inspection. It is, however, recommended that the latest OFSTED inspection report/rating is available to the inspection team for background.

## Who to Speak to

- 6.21. The following are interviews with the leadership team for CYP that I recommend should be undertaken at every inspection (ideally towards the end of the inspection to take into account what has been observed and discussed):
- Clinical director/lead
  - Nursing lead
  - Directorate/divisional manager
  - Non-executive director on the Board with responsibility for CYP
- 6.22. The following is a suggested list of people (not all of which are CYP specific) who I recommend the CYP inspection sub team should always speak to:
- Patients/parents
  - Named doctor/nurse for safeguarding
  - Children's specialist nurses from a range of specialities
  - Play specialists
  - Trust paediatric anaesthetic lead - for a perspective of how CYP are looked after across the trust
  - Trust paediatric radiology lead – for a perspective of how CYP are looked after across the trust
  - Senior representative from the Trust pathology service – it will be important to see how pathology services in acute trusts take into account the needs of CYP eg, appropriate sized blood samples etc
  - Paediatric pharmacist - safety requirements are very different to that for adults
  - Governance lead for CYP – paediatricians can be employed by different parts of the trusts eg. A&E, theatres, children's department etc
  - Adult lead for transition
  - Safeguarding team (following liaison with CQC's children's services inspection team)
  - Paediatric liaison
  - Children's community nurses and liaison health visitors (even if employed by another trust)
- 6.23. The following is a suggested list of people (not all of which are CYP specific) with whom I recommend that discussions/observations could also be held to gather additional evidence about the CYP service:
- AHP staff
  - Matrons, Nurses & Healthcare Support Workers
  - Doctors
  - Support staff eg. ward managers, porters, receptionists, admin etc
  - PALS

## What to ask

- 6.24. During general discussions with staff that inspectors speak to opportunistically in CYP settings, I recommend that they should ask:
- What makes you most proud about working here?
  - What worries you about working here?
  - Would you be happy for your own child to be treated here?

- 6.25. During general discussions with parents that inspectors speak to opportunistically in CYP settings, I recommend they should ask:
- Tell me about your and your child's experience of this service - what is good and what needs improvement?
  - Are you confident leaving your child's care with the staff on the ward when you have to leave? If not, what are your concerns?
- 6.26. During general discussions with CYP, I recommend they should be asked:
- What is it like here?
  - What would make your stay better?
- 6.27. For each of CQC's 5 domains (safe, effective, caring, responsive & well-led), it is recognised that CQC wish to use a set of generic Key Lines of Enquiry (KLOE) to ensure consistency of approach for inspections and the resulting ratings. **Annex G** sets out a list of CYP related prompts that I recommend should be used for each generic KLOE – this is not a definitive list as analysis of the datapack and on-site observations may identify further prompts, however, it will ensure that key CYP specific issues are always considered for each inspection. I understand that the generic KLOEs are evolving and may change. If they do change significantly these prompts should not be lost – I recommend that they need to be incorporated within any updated KLOEs.
- 6.28. It is important to note that for an acute inspection, the other core service inspection teams may need to consider some CYP issues - this will need to be agreed at the start of the inspection. As a minimum, I recommend that all acute sub-teams (except maternity) ask about transition to adult services (see **Annex G R1**) and comment on this in their section of the trust report.

### Knowing what good looks like

- 6.29. To support consistent judgements it will be important for inspection teams to have a shared view of '*what good looks like*' for CYP services in acute and specialist trusts. There is a wide range of national guidance, guidelines and standards by a range of national organisations (e.g. NICE) and professional bodies related to CYP services. Some, but not all, of these are supported by national data. **Annex Hi** lists the range of documentation available and **Annex Hii** shows which of these are supported by national data.
- 6.30. In an ideal world, CYP services would be fully compliant with all these documents and would also be taking part in all nationally recommended national audits, delivering services within acceptable limits as determined by professional bodies. It will not be feasible for CQC to consider services against all guidance, standards and audits (at least not at the present time). I have not been able to obtain a model for how CQC wants to present '*what good looks like*'. I have therefore produced a starter for 10 that could be used as a proxy to judge whether CYP services (general or specialist) are good (i.e. a service we would be happy for our friends and family to be seen and treated in). This is set out at **Annex li**.
- 6.31. Whilst this description of '*what good looks like*' can be used as a guide for inspection of acute and specialist trusts, I would advise some caution. I have had to be pragmatic in describing a good service in order to set CQC inspection teams a realistic task. In doing so there could be unintended consequences, for example, there is a danger that trusts will

only focus on the areas highlighted at the expense of other areas which will also be key in ensuring CYP services are safe, effective, caring, responsive and well-led. This draft of '*what good looks like*' should therefore be developed further and kept under review. This should be the responsibility of the national professional advisors (NPAs) I recommend in **section 10**, working with the RCPCH and affiliated speciality groups.

- 6.32. In addition to '*what good looks like*', I have included some examples of what I might expect to see in an outstanding CYP service at **Annex lii**. I have also highlighted examples of issues that would indicate that a CYP service either requires improvement or is inadequate. These are set out at **Annexes liii** and **liv** respectively.

### Summary of Recommendations

#### Short Term

1. A flexible approach to inspecting CYP services will be needed on acute inspections. The CYP sub team needs to consider how it works with the other core service teams to ensure that issues related to CYP are adequately addressed across the pathway ( from A&E to EOLC). As a minimum, all 'adult' core service sub teams (excluding maternity) need to ask about transition to adult services and comment on this in their section of the trust report.
2. The acute inspection team should always include a doctor who has completed training in paediatrics and a children's nurse. A parent of a child that has used health services should be an expert by experience on the team if possible.
3. Inspection of specialist children's hospitals/large tertiary providers need to include the clinical experts listed at **para 6.10** plus at least two (ideally four) parents of children who have experience of the health service.
4. Pharmacists on the acute team should ask specific questions in relation to medicines managements in relation to CYP – a paediatric pharmacist should be on inspection team for specialist children's trusts and large tertiary children's services.
5. CYP services should always be visited at night – if this cannot be scheduled during the announced visit then it should be part of the out of hours unannounced inspection.
6. Case note tracking should be used during the inspection to follow the pathways of a number of children during the inspection period.
7. The areas listed at **para 6.16** should always be included as part of the inspection.
8. The people listed at **paras 6.21-6.22** should always be interviewed as part of the inspection.
9. The list of CYP specific prompts for generic KLOEs should be shared with inspection teams in advance and used during the inspection to ensure consistency of approach – if the KLOEs change then these prompts should be built into the new KLOEs.
10. A visit to a sample of satellite and/or outreach services should be arranged by exception if there are concerns.

#### Medium term

- CYP sub team leaders need background knowledge and experience of inspecting CYP services – the CQC Academy should introduce a programme to develop CQC inspectors in this area.
- Young people (over 19s) with experience of hospital should be encouraged to take part in inspections.

#### Long term

- The description of '*what good looks like*' for CYP services should be developed further and kept under review by the NPAs recommended in **section 10** working with the RCPCH and affiliated speciality groups.

## **7. Additional considerations for inspection of specialist children's trusts and large tertiary providers**

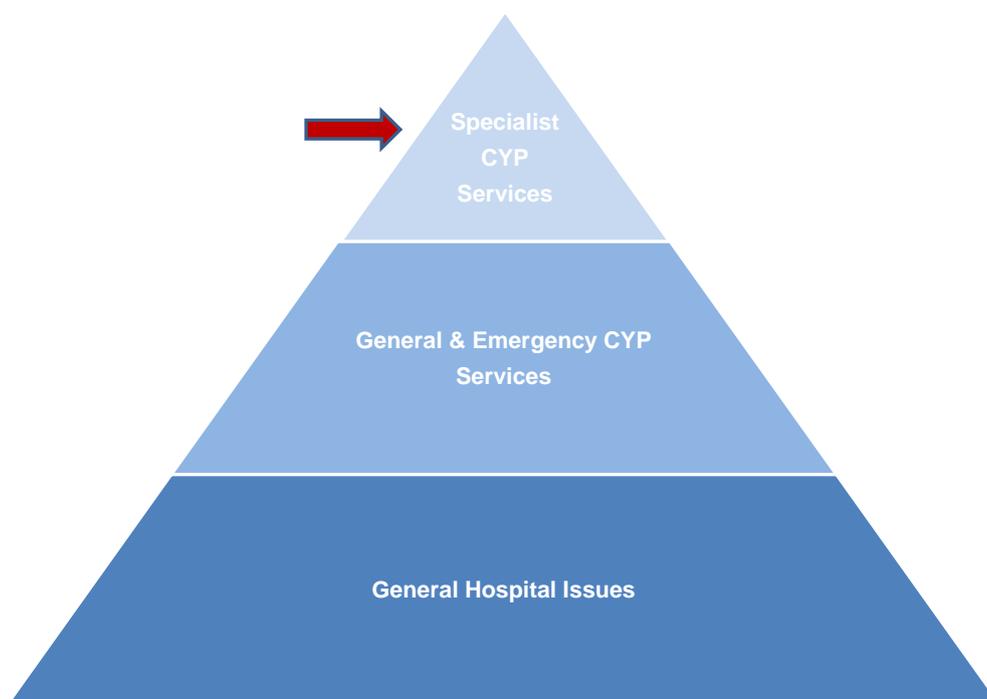
### **Key points**

- Large tertiary providers should be inspected in the same way as the standalone specialist children's trusts.
- The inspection team needs to include a range of clinical experts and at least two (preferably four) parents.
- The eight core services for specialist children's trusts and large tertiary providers should be A&E, medicine, surgery, critical care, neonatal services, adolescent & transition services, palliative & end of life care and outpatients.
- It will not be feasible to inspect each of the 41 specialised health services relevant to CYP - a sample should therefore be considered as part of the inspection of specialist children's trusts and large tertiary providers based on audit data and stakeholder feedback. Two specialised services should also be chosen at random for inspection.
- Consideration of the specialised services should be built into the inspection of the most appropriate core service category – this will mainly be medicine and surgery.
- The inspection team cannot reasonably be expected to have a detailed understanding of all 41 specialised service areas that are relevant to CYP. They therefore need to focus on system and process rather than specific clinical expertise.
- The CYP specific prompts that have been developed to support the KLOEs for the acute inspection model (see **Annex G**) cover the majority of issues that need to be addressed when specialist children's trusts and large tertiary providers are inspected. There are a small number of additional issues that should be addressed in the safe, effective and responsive domains.
- Predominantly adult specialist hospitals that provide some services for children and young people should be inspected in the same way as CYP services in acute trusts with an appropriate specialist paediatrician and/or specialist children's nurse on the inspection team for larger services.

- 7.1. This section focuses on modifications to the acute inspection methodology needed when CQC inspects specialist children's trusts and large tertiary providers. It is informed by the stakeholder event on 28th January (see **Annex C**) and specific advice from staff working in tertiary environments. It also addresses inspection of other, predominantly adult specialist trusts that see and treat some children & young people (CYP).

## Overview

- 7.2. In England there are four standalone specialist children's trusts and a number of acute trusts with children's hospitals or large tertiary children's services. I recommend that large tertiary providers should be inspected in the same way as the standalone specialist children's trusts. CQC will need to agree a definition to identify the providers that would fall into this category in terms of size and range of specialist services. I understand that CQC analysts have started some work that should help with this. Organisations that I would expect to be included within any agreed list are set out at **Annex A**.
- 7.3. As set out at **para 3.2**, the acute hospital inspection model can be divided into three areas:
- general hospital issues;
  - general & emergency CYP service issues;
  - specialist CYP service issues.
- 7.4. Whilst inspection of general hospital and general & emergency CYP issues will be the same for acute and specialist children's trusts, there are some modifications to the process that will be needed to address the specialised service element in specialist children's trusts and large tertiary services. These are set out below:



## Who should be on the inspection team

- 7.5. See recommendations at **paras 6.10 and 6.11**.

## What to inspect

7.6. The methodology for standalone specialist children's trusts and other large tertiary providers should be the same in terms of general hospital and general and emergency CYP services as for acute hospital inspections. This includes inspecting 6 of the 8 core services from the acute model as follows:

- A&E;
- Medicine;
- Surgery;
- Critical Care;
- Palliative & End of Life Care - for acute, this is referred to as 'End of Life Care' but for specialist children's services it should be renamed as shown;
- Outpatients.

7.7. The remaining two core services from the acute model need to be replaced as follows:

- Maternity to be replaced by Neonatal services;
- General CYP (which will now be included within the 6 services above) to be replaced with Adolescent & Transition Services.

7.8. General issues related to governance and complaints etc will need to be considered as part of the specialist children's trust inspections. For the large tertiary providers these issues will be picked up as part of wider trust considerations.

### *Neonatal services*

7.9. Neonatal services are provided for new born babies who need extra care, for example, because they are born prematurely or become ill and need treatment in hospital. There is a NICE Quality Standard for specialist neonatal care services that can inform the CQC inspection of this service. I recommend that CQC makes contact with BLISS, a charity that works with health professionals and families to ensure care for premature and sick babies is of a high standard, to develop its inspection of neonatal services further and also to identify parent representatives who might be willing to join inspection teams as '*experts by experience*'.

### *Adolescent & Transition Services*

7.10. Adolescence is a developmental stage distinct from childhood or adulthood and encompasses several age bands and stages. The inspection needs to consider whether young people's services are fit for purpose and if the needs of adolescents in transition to adult services are being addressed. The key issues for inspectors to consider (which have been built in to **Annex G**) are whether services are young people friendly and age and developmentally appropriate and I recommend that these are addressed during inspections.

7.11. It is also important that adult services (in acute trusts and large tertiary providers) come under scrutiny for the 16 to 25 year olds that they see and treat whether a new patient or someone who has transitioned from CYP services. The inspection needs to ensure that these services genuinely support young people (with or without long term conditions) accessing health services and that they are not lost among the increasing population of older people. Some prompts have been built in to **Annex G** to support this and I recommend that these are used.

### Specialist Services

- 7.12. Some children have serious or complex needs that are best dealt with by specialist health services. There are currently 23 service areas recognised as specialised paediatric health services (see **Annex Ji**) and a further 18 specialised services which cover both adults and children (i.e. 'all ages' definitions) (see **Annex Jii**).
- 7.13. It will not be feasible to inspect each of these specialised services – in the same way as it is not feasible to inspect all outpatient clinics as part of an acute trust inspection or all community services as part of inspection of community trusts. I therefore recommend that a sample of specialised services is considered as part of the inspection of specialist children's trusts and large tertiary providers. This selection should be based on audit data and stakeholder feedback where available. I also recommend that two specialised services are always considered at random so that all specialised services could potentially receive a visit as part of the CQC inspection. This would ensure that trust's do not prioritise some specialised services over others on the basis of perceived CQC 'interest'.
- 7.14. It is recommended that consideration of specialist services is built into the inspection of the most appropriate core service category, mainly medicine or surgery, as follows:

Core service	Specialist service
Medicine	Specialised Paediatric Cancer Services (paediatric oncology, malignant haematology and cancer surgery services) Specialised Paediatric Endocrinology and Diabetes Services Specialised Paediatric Gastroenterology, Hepatology and Nutritional Support Services Specialised Paediatric Gynaecology Services Specialised Paediatric Haematology Services (excluding malignant haematology, bleeding disorders and haemoglobinopathies) Specialised Paediatric Neurosciences Services Specialised Paediatric Ophthalmology Services Specialised Paediatric Renal Services Specialised Paediatric Respiratory Services Specialised Services for Blood and Marrow Transplantation (all ages) Specialised for Haemophilia and Other Related Bleeding Disorders (all ages) Cystic Fibrosis Services (all ages) Specialised Clinical Immunology Services (all ages) Specialised Services for Allergic Disease (all ages) Specialised Services for Infectious Diseases (all ages) Specialised Medical Genetic Services (all ages) Specialised Dermatology Services (all ages) Specialised Rheumatology Services (all ages) Specialised Ear Services (all ages) Morbid Obesity Services (all ages) Specialised Metabolic Disorders Services (all ages) Specialised Haemoglobinopathies Services (all ages)

Surgery	Specialised Paediatric Anaesthesia and Pain Management Services Specialised Paediatric Cardiology and Cardiac Surgery Services Specialised Paediatric Dentistry Services Specialised Paediatric Ear, Nose and Throat Services Specialised Paediatric Oral and Maxillofacial Surgery Services Specialised Paediatric Orthopaedic Surgery Services Specialised Paediatric Plastic Surgery Services Specialised Paediatric Surgery Services Specialised Paediatric Urology Services Specialised Spinal Services (all ages) Specialised Burn care Services (all ages) Cleft Lip and Palate Services (all ages)
Critical care	Specialised Paediatric Intensive Care Services
Outpatients	Specialised Paediatric Rheumatology Services The Assessment and Provision of Equipment for People with Complex Physical Disability (all ages)
End of Life Care	Specialised Paediatric and Perinatal Post Mortem Services

Note:

- Specialised Paediatric Mental Health (Tier 4 CAMHS and Forensic) Services should be considered as part of the development of the mental health inspection model
- Specialised Mental Health Services (all ages) should be considered as part of the development of the mental health inspection model

### Knowing what good looks like

7.15. The inspection team cannot reasonably be expected to have a detailed understanding of all specialist service areas that are relevant to CYP. I therefore recommend that the inspection of specialist services needs to focus on system and process rather than specific clinical expertise. The national service specification for the area being inspected, alongside any feedback from commissioners on these areas, would provide useful indicators of whether a service is ‘good’ ahead of an inspection. Some examples of good and outstanding practice as well as examples of issues that would require improvement or are inadequate in relation to specialist services have been built into **Annexes li-iv**. These need to be developed further and kept under review by the National Professional Advisers recommended in **section 10**.

### What to ask?

7.16. The CYP specific prompts that have been developed to support the KLOEs for the acute inspection model (at **Annex G**) cover the majority of issues that need to be addressed when specialist children’s trusts and large tertiary providers are inspected. However, there are a small number of additional issues that should be addressed for these specialist providers in relation to CQC’s safe, effective and responsive domains:

#### *Safe*

- What arrangements are in place for the transfer of CYP between acute and specialist trusts/ large tertiary providers?
- How do you contribute to relevant specialist networks – what evidence is there of support to networks through education, training and shared protocols e.g. an identifiable network lead for each service and a point of contact for non-urgent enquiries and referrals etc?
- How do you contribute to relevant shared care arrangements with local providers?

### *Effective*

- What evidence is there of compliance with National Specialised Service Specifications, what deviations/ derogations and plans (with timeframes) to become fully compliant?
- How does the trust discharge its responsibilities as a tertiary provider i.e.:
  - giving timely advice to secondary care providers;
  - accepting referrals in a timely manner;
  - managing step down/transfer of care back to an acute trust/community when the time is right ie supporting acute trusts (or others) with discharge info etc;
  - supporting secondary care staff to develop specialist competencies as appropriate?
- What evidence is there of support to networks through education, training and shared protocols. For example, is there an identifiable network lead for each service? Is there a point of contact for urgent and non-urgent enquiries and referrals?

### *Responsive*

- What accommodation and facilities are available for families travelling large distances from home (e.g. hotel-type services as opposed to hospital facilities)

These have been built into **Annex G**.

### **Predominantly adult specialist hospitals**

7.17. There are seven non-child specific standalone specialist trusts that provide some services for children and young people. These are:

- Queen Victoria Hospital NHSFT (reconstructive surgery, burns care and rehabilitation)
- Royal Brompton and Harefield NHSFT (cardiothoracic)
- Moorfields Eye Hospital NHSFT (eye)
- Royal National Orthopaedic Hospital NHS Trust
- Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHST
- The Royal Orthopaedic Hospital NHS FT
- Royal National Hospital For Rheumatic Diseases NHS FT

7.18. I recommend that these trusts are assessed in the same way as the CYP services within the acute hospital inspection model but that consideration is given to including an appropriate specialist paediatrician and/or specialist children's nurse on the team for larger services such as those provided by the Royal Brompton and Harefield NHSFT and the Royal National Orthopaedic Hospital NHS Trust inspections.

7.19. There are also two specialist trusts (Birmingham Women's NHSFT and Liverpool Women's NHSFT) that do not provide CYP services but do have neonatal units. I recommend that a neonatologist and a neonatal nurse is included within the inspection team for these trusts.

## Summary of Recommendations

### *Short term*

- Inspection of specialist children's hospital/large tertiary providers need to include the clinical experts listed at **para 6.10** plus at least two (preferably four) parents of children who have experience of the health service.
- The eight core services for specialist children's trusts and large tertiary providers should be A&E, medicine, surgery, critical care, neonatal services, adolescent & transition services, palliative & end of life care and outpatients.
- A sample of the 41 specialised health services relevant to CYP should be chosen for inspection (based on audit data, stakeholder feedback, plus two chosen at random) and inspected as part of the most appropriate core service – the focus should be on system and process rather than specific clinical expertise.
- CYP specific prompts that have been developed to support the KLOEs for the acute inspection model should also be used for specialist children's trusts and large tertiary providers with the addition of a small number of additional prompts in the safe, effective and responsive domains , for example, related to shared care.

### *Medium term*

- Large tertiary providers of CYP services should be inspected in the same way as the standalone specialist children's trusts.
- CQC should work with BLISS to develop its inspection of neonatal services.
- The non-child specific standalone specialist trusts should be assessed in the same way as the CYP services within the acute hospital inspection model with an appropriate specialist paediatrician and/or specialist children's nurse included on the team for larger services. A neonatologist and neonatal nurse should be included on the inspection team for the two specialist women's trusts.

## 8. Report & Quality Summit

### Key Points

- Information about the CYP service (with the exception of children's A&E) should go into a single section of an acute trust inspection report with appropriate cross references in the other core service sections.
- For acute trusts, CYP services should be rated as a whole i.e. taking into account all core services with the exception of A&E. There should be a single A&E rating taking into account both CYP and adult A&E.
- The report for the Specialist Children's Trusts should be structured around the 8 core services recommended in **section 7** (A&E, medicine, surgery, critical care, neonatal services, adolescent & transition services, palliative & end of life care and outpatients) with a rating provided for each of these services aggregated up to a trust rating.
- Acute trusts with large children's tertiary providers will need to be rated against 7 of the 8 core services used for acute trusts (i.e. all except CYP services) with CYP services inspected and rated as for specialist children's trusts.
- The Quality Summit for specialist children's trusts and large tertiary providers does not need to differ from those for acute trusts.

8.1. This section focuses on how best to report on the inspection of services for children & young people (CYP) as part of both acute and specialist trust inspections and the implications for the presentation of ratings. It also advises on the Quality Summit. These were not issues that were considered as part of the stakeholder event on 28<sup>th</sup> January. My recommendations are therefore based on discussions with my task and finish group including the CQC Head of Hospital Inspections who leads on the CYP core service.

### Report & Rating

#### *Acute trusts*

- 8.2. I was informed that a decision had already been made that all CYP inspection information would go into a single section of an acute trust inspection report. I am content with this approach as long as there are appropriate cross references in the other sections of the report so that CYP issues are not forgotten and leverage to improve issues does not just sit within the CYP directorate of a Trust. For example, the surgery section of the acute trust report needs to cross refer to the CYP section in relation to CYP surgery issues etc.
- 8.3. This approach means that the CYP service would most sensibly be rated as a whole (from A&E to EOLC) with ratings for the trust's other core services (e.g. outpatients) excluding the CYP element. However, this has raised concerns in relation to the A&E ratings as children's A&E services are generally part of the emergency rather than the children's directorate of a trust. A range of options to address this have been discussed including:

- rating the CYP service as a whole (from A&E to EOLC) with ratings for the individual core service (eg. A&E, surgery) excluding the CYP element;
- rating each core service (A&E, surgery etc) as adult and CYP combined then excluding that service from the CYP rating. This option does not leave much for inclusion in the CYP rating;
- rating each core service (A&E, surgery etc) as adult and CYP combined but also bring all the CYP elements together for an overarching CYP rating – this would lead to duplication i.e. with the CYP services in effect being rated twice;
- excluding A&E from the CYP rating (ie A&E rating covers adults and CYP combined but the remainder of services (surgery, o/p etc) are included in the CYP rating.

8.4. I recommend the last option i.e. that CYP A&E should be included with adult A&E to provide a single A&E rating. This is because children’s A&E services are generally part of the emergency department’s directorate rather than the CYP directorate. However, commentary related to this rating for CYP must be clearly visible in its own right in the A&E section so as not to be masked by general A&E issues. Relevant aspects of the CYP A&E section should be repeated the CYP section of the inspection report for completeness.

#### Specialist Children’s Trusts & Large Tertiary Providers

8.5. The report for the Specialist Children’s Trusts should be structured around the 8 core services recommended in **section 7** i.e:

- A&E (if provided)
- Medicine
- Surgery
- Critical Care
- Neonatal services (if provided)
- Adolescent & Transition Services
- Palliative and End of Life Care
- Outpatients

8.6. There should be a rating for each of these core services which would be aggregated to provide an overall specialist children’s trust rating as shown in the following mock up rating grid:

X Specialist Children's Trust						
	S	E	C	R	WL	Overall
Accident & Emergency	I	RI	RI	I	RI	I
Medical care	RI	RI	RI	RI	RI	RI
Surgery	G	G	G	G	G	G
Critical care	G	G	G	G	G	G
Neonatal Services	RI	G	G	RI	RI	RI
Adolescent & Transition Services	RI	G	G	G	RI	RI
Palliative & End of Life	G	G	G	G	G	G
Outpatients	G	RI	G	G	G	G

X Specialist Children's Trust					
Safe	Effective	Caring	Responsive	Well-led	Overall
RI	G	RI	RI	RI	RI

Note: G = good; RI = requires improvement; I = Inadequate

- 8.7. It is recommended that the same approach is taken for large tertiary CYP services in acute trusts. This will mean that providers of large tertiary children's services within an acute trust will have a different rating grid to either acute trusts or standalone specialist children's trusts. They will have a grid for 7 of the 8 core services (i.e. excluding CYP services) and a separate grid that breaks down the CYP line into 7 of the 8 core services set out at **para 8.5** (i.e. excluding A&E). These two ratings grids would need to be aggregated to provide an overall location/trust rating as shown in the following mock up rating grids:

X Trust						
	S	E	C	R	WL	Over All
Accident & Emergency (CYP & adult)	RI	RI	RI	RI	G	RI
Medical care	G	RI	G	RI	G	RI
Surgery	G	G	G	RI	G	G
ritical care	G	G	G	G	G	G
Maternity & family planning	RI	G	G	G	RI	RI
Services for CYP						
End of Life	G	G	G	G	G	G
Outpatients	RI	RI	G	RI	G	RI

X Trust's Specialist CYP Services						
	S	E	C	R	WL	Over All
Medical care	RI	RI	RI	RI	RI	RI
Surgery	G	G	G	G	G	G
Critical care	G	G	G	G	G	G
Neonatal Services	RI	G	G	RI	RI	RI
Adolescent & Transition Services	RI	G	G	G	RI	RI
Palliative & End of Life	G	G	G	G	G	G
Outpatients	G	RI	G	G	G	G

X Trust's overall rating					
Safe	Effective	Caring	Responsive	Well-led	Overall
RI	G	RI	RI	RI	RI

### *Quality Summit*

- 8.8. There is no need for the Quality Summit for specialist children's trusts or large tertiary providers to differ from those for acute trusts.

#### **Summary of Recommendations**

##### *Short term*

- Information about the CYP inspection should go into a single section of an acute trust inspection report but there should be appropriate cross references to the other sections of the report.
- CYP services should be rated as a whole, taking into account all the core services with the exception of A&E which should be rated with adult A&E to provide a single A&E rating for acute trusts.
- The report for the Specialist Children's Trusts should be structured around the 8 core services recommended at **para 8.5** with a rating provided for each of these services which would aggregate up to a trust rating.
- The Quality Summit for specialist children's trusts and large tertiary providers does not need to differ from those for acute trusts.

##### *Medium term*

- Large tertiary providers will need to be rated against 7 of the 8 acute core services (excluding general CYP services) with a separate rating grid for CYP in line with that used for specialist children's trusts.

## 9. Links to other programmes

### Key Points

- CYP do not sit neatly within one organisation. CQC must not lose sight of the overall pathway of care for CYP. The interface between its different inspection programmes will be key.
- A modular approach is needed to the inspection of CYP services at a provider level i.e. building in the appropriate modules from the relevant inspection models rather than subjecting the provider to multiple inspections.
- CQC is only at the start of the journey in developing a process for CAMHS that is fit for purpose.
- The importance of children's community nursing cannot be over emphasised. Links need to be made between the acute and community inspection programmes on this.
- CQC should reconsider if children's hospices are best inspected as part of the adult social care sector. Children's hospices are very different to adult hospices.

### Mental Health

9.1. The acute, community and mental health inspection models need to take into account a number of issues including:

- CYP with distinct mental health and physical health needs;
- CYP in acute settings with mental health needs below the threshold for CAMHS;
- CYP who deliberately self harm and present to A&E;
- young people with mental health problems on adult wards;
- how the physical needs of CYP in CAMHS are met.

Cross fertilisation between the mental health, community and acute inspection models as they evolve will be vital. In the interim I have built paediatric liaison into the acute inspection model.

9.2. Child & Adolescent Mental Health Services (CAMHS) are really important for CYP. I was therefore pleased to find out that the inspection model for mental health trusts being piloted includes child & adolescent mental health services (CAMHS) as one its core services. I chaired a CAMHS workshop on 18 March 2014 attended by a range of stakeholders to seek their views on the development of the CAMHS inspection module (see **Annex K** for attendance). This was a constructive meeting which generated a number of ideas for how to enhance CQC's inspection of CAMHS throughout the process from producing datapacks to the inspection itself. CQC must harness the enthusiasm that the workshop generated to move this agenda forward in consultation with stakeholders. CQC is only at the start of the journey in developing a process for CAMHS that is fit for purpose. I recommend that:

- CQC analysts work as a priority with relevant stakeholders from the workshop to finalise what the datapack should include for CAMHS;
- CQC policy colleagues involve stakeholders in the development of products such as prompts for KLOEs and what good looks like;
- the CAMHS module, when ready, is included in relevant acute and specialist inspections.

## Community Health Services (CHS)

- 9.3. It is encouraging that CYP has been identified as a core service for the developing inspection model for community trusts. This is the model that I have found the hardest to influence. I have shared some early thoughts and links to useful documents to inform '*what good looks like*' with colleagues in CQC leading on this work but I have not seen or been able to contribute to any recent draft documents which has been disappointing. The importance of children's community nursing cannot be over emphasised and I am unclear if and how this is being addressed in the community model to support CYP with short or long term illnesses, complex needs and disabilities. Links therefore still need to be made between the acute and community programmes on this. I recommend that steps are taken to ensure the community inspection programme not only comprehensively captures children's services but reflects the importance of pathways of care for CYP between primary, community, acute and tertiary/specialist care services. In **section 10**, I make recommendations for national professional advisors (NPAs) to support CQC taking forward the CYP programme as a whole. One of these NPAs would ideally be a community paediatrician or community children's nurse.

## Ambulances and children's intensive care transport teams

- 9.4. The **ambulance service** inspection model is at a very early stage of development. Emergency services must accommodate CYP with age appropriate safety and resuscitation equipment and personnel trained to administer emergency care to all age groups. The care given to CYP by emergency services needs to be reviewed regularly with a specific CYP focus on SUIs/incidents/mortality involving the emergency services.
- 9.5. It will also be important to consider hospital transfers such as why CYP are moved, for example, is this because there was no bed or because the trust could not provide the care needed. It is not yet clear whether CQC envisages inspection of the specialist transport teams being part of the ambulance inspection model. Irrespective of the final decision on this, I recommend that the clinical side of **children's intensive care transport teams** needs to be inspected as part of the inspection of the '*parent*' trust. CQC will need to undertake some further work to build this into the acute and specialist trust inspections. My early advice is that:
- the following should be built into the datapacks:
    - Number of CYP more than 180mins from acceptance to arrival (CQUIN target)
    - Number of retrieval requests refused
    - Proportion of CYP unable to be placed in preferred ICU (i.e. the ICU appropriate for clinical network arrangements)
    - Proportion of CYP taken out of catchment area
    - Critical incidents
  - The following should be considered in relation to the CQC domains:
    - safe: are CYP transported as safely as possible (audit adverse incidents/operational policies/team training including ambulance technicians) and do CYP receive timely and appropriate resuscitation (outreach education and liaison with DGHs);

- effective: do CYP receive intensive care in most appropriate place (number of children taken out of region/proportion preferences upheld).
- responsive: single point of contact for the referring trust and transport service/ formal outreach and liaison roles in place/outreach programme delivered with shared Mortality & Morbidity meetings.
- well-led: evidence that service delivers a managed clinical network for children's critical care needs; daily review of all referrals and outcomes/incidents; designated medical and nursing lead; annual report.

9.6. Whilst work to develop inspection of children's intensive care transport teams takes place, I would recommend that CQC enquires in the interim, as part its Q1 acute and specialist hospital inspections, if:

- trusts with emergency services for CYP and in-patient beds:
  - monitor the number of secondary care transfers due to lack of beds;
  - treat each transfer due to lack of beds as a critical incident;
  - present data on this regularly to the executive board as part of the children's governance report.
- trusts with emergency services for CYP without inpatient beds:
  - have robust plans in place for secondary transfer that are agreed with the local ambulance provider;
  - that these plans are monitored and reviewed in regular joint governance meetings between the hospital and ambulance trusts.

## Safeguarding

9.7. CQC is currently carrying out a single-agency programme of safeguarding inspections in 110 areas previously graded as adequate or inadequate during the last safeguarding and looked after children's inspection programme. This programme is due to complete in August 2015. These reviews are carried out under section 48 of the Health & Social Care Act 2008 and CQC's children's services inspection team reviews the safeguarding and looked after children's services being provided by mental health partnerships (both CAMHS and adult mental health services), health visitor teams, school nurses, community maternity services, substance and alcohol misuse services, sexual health clinics, minor injury, walk-in centres and acute hospitals – specifically maternity services and A&E departments. Findings from these reviews are shared with regionally based CQC staff who hold the relationship with the trusts and are recorded by analysts so that findings can be incorporated into other inspection briefs.

9.8. I recommend that the links between the children's services inspection team (which has recently moved into the directorate of the Chief Inspector of General Practice) and the acute, community and mental health inspection teams are formalised to ensure that teams are aware of each other's inspection schedules and can share information and advice as needed. For the acute and specialist trust inspections in particular, I would recommend that the children's services inspection team is asked to develop a '*safeguarding module*' for use in those hospital inspections where there has not been a recent single agency inspection. This module would need to look at key areas of the acute hospital, for example, A&E, children's assessment unit, maternity and some ward areas. If the findings from this module indicate significant risks to CYP in terms of safeguarding, then this would be shared with the children's services inspection team, which would then schedule a single agency inspection based on increased risk. For those areas where a single agency inspection has just been carried out, the

findings would need to form part of the pre-inspection datapack and could inform further lines of enquiry or follow up against the submitted action plan as advised by the children's services inspection team. Members from this team could also be invited to join the acute or specialist inspection team as needed.

- 9.9. In April 2015, the multi-agency child protection inspections (conducted with Ofsted, HMI Probation, HMI Prisons and HMI Constabulary) will resume and will run alongside the CQC's single agency programme. This multi-agency programme will look at those areas selected as high risk, and a smaller number of '*good practice*' areas. I have been assured that there are no plans to subsume the CQC single agency safeguarding inspections into a multi-agency inspection programme. It is anticipated that from September 2015, the children's safeguarding single agency inspection will become part of the integrated care inspections being developed in the Primary Medical Services and Integrated Care directorate. I would recommend, however, that the children's services inspection team need to link across to all CQC inspection models (acute, community, mental health, ambulance and hospices) as they relate to children.

### **Primary Care**

- 9.10. I had an early discussion with Professor Steve Field, the Chief Inspector of General Practice, and was pleased to hear that '*mothers, children and young people*' had been specifically identified as one of the groups that the general practice inspection model would focus on. However, with the exception of making links to the CQC surveillance team to inform discussions on what information might be useful as part of an intelligent monitoring tool in primary care, there have not been staff in post to liaise with on this model. I have not therefore been able to advise on the development of the new model for inspections of GP practices and out of hours services as part of my work. However, I understand that a Deputy Chief Inspector and a Head of General Practice inspection will be in post from 1 April 2014 with CYP in their portfolios. It is important that they work with colleagues on the other inspection models to consider the whole pathway for CYP.

### **Children's Hospices**

- 9.11. Children's hospices currently sit within the portfolio of the Chief Inspector of Adult Social Care. Whilst there may be good regulatory reasons for children's hospices to be considered as part of the social care sector, children's hospices are very different to adult hospices in terms, for example, of the dependency and complexity of the CYP being looked after. The CYP community needs to have confidence that children's hospices will be adequately addressed as part of the adult social care sector inspection model. I have had an opportunity to consider the work in progress on the hospice inspection model in terms of KLOEs and '*what good looks like*'. Inevitably, because it is generic there isn't as much detail on CYP as I would like. Successful inspection of children's hospices will therefore have to rely on the inspection team having the expertise to apply the generic to CYP. I recommend that the inspection team includes clinical expertise in children's hospices. Links to the palliative care network and medicines management will need specific consideration and user views (including parents) will need to be obtained. I also recommend that CQC's Academy develops a training model for CQC inspectors who will be responsible for leading inspection in children's hospices to ensure they have the necessary knowledge and expertise to lead these teams.

9.12. I also recommend that CQC seriously considers whether inspection of children’s hospices might sit better under the portfolio of either the Chief Inspector of General Practice due to his responsibility for integrated care and also the fact that GPs continue to provide medical support for many of these establishments or the Chief Inspector of Hospitals to keep the link with hospital services as part of palliative care provision.

### **Independent Sector**

9.13. I recommend that where an NHS acute or specialist trust provides CYP services on a private basis, these should be considered as part of the NHS inspection rather than arranging a second visit. If the CQC is not aware of which trusts provide/offer private services for CYP then I recommend that this information is requested as part of the information request form to the trust that informs the datapack.

9.14. When inspecting independent sector providers that provide CYP services, a consultant paediatrician and a children’s nurse, should be part of the inspection team. If children under three are treated in standalone independent sector hospitals then I recommend that a detailed inspection is undertaken with appropriate clinical experts on the team as there could be a range of safety issues, for example, related to anaesthetics and surgery.

### **Pathways of Care**

9.15. CYP do not sit neatly within one organisation. I recognise that CQC has to hold an individual provider accountable, however, the CQC must not lose sight of the overall pathway of care for CYP. The interface between its different inspection programmes is therefore key. The CMO in particular is supportive of considering patient journeys even if the focus of an inspection is on a single organisation. She is particularly concerned about children falling through gaps in services due to the changing landscape.

9.16. I recommend that a modular approach is taken to the inspection of CYP services including the interfaces between organisations. For example if an acute trusts has an embedded CAMHS, then the acute model should be used with the CAMHS modules from the mental health inspection model rather than the CAMHS service being picked up as part of a separate mental health inspection.

## **Summary of Recommendations**

### *Short Term*

- CQC analysts work with stakeholders to finalise what the datapack should include for **CAMHS**.
- CQC policy colleagues involve stakeholders in the development of products such prompts for KLOEs and what good looks like for **CAMHS**.
- Issues related to **hospital transfers** need to be built into relevant KLOEs.
- The children’s services inspection team need to link across to all CQC inspection models (acute, community, mental health, ambulance and hospices) on **safeguarding** including scheduling of inspections and sharing information and advice as needed.
- **Children’s hospice** inspection teams should include relevant clinical experts.
- Children under three being treated in standalone **independent sector** hospitals should be regarded as at high risk and a detailed inspection be undertaken with appropriate clinical experts.

### Medium Term

- The **community** inspection programme needs to comprehensively capture children's services and reflect the importance of pathways of care – appointing a national professional advisor should help with this.
- The newly appointed Deputy Chief Inspector for **general practice** and Head of General Practice Inspection with CYP in their portfolios need to work with colleagues on the other inspection models to consider the whole pathway for CYP.
- A **safeguarding** module should be developed for acute and specialist trust inspections to use in hospitals where there has not been a recent single agency safeguarding inspection.
- CQC's Academy should develop a training module for CQC inspectors who will be responsible for leading inspection in **children's hospices** to ensure they have the necessary knowledge and expertise to lead these teams.
- The **ambulance service** inspection model must address the needs of CYP as it continues to develop.
- The clinical side of **children's intensive care transport teams** needs to be inspected as part of the inspection of the 'parent' trust. CQC need to undertake further work on this and use the proposed KLOE prompts in the interim (see para 9.5 & 9.6).
- Where an NHS acute or specialist trust provides CYP services on a **private** basis, these should be considered as part of the NHS inspection rather than a second inspection - if the CQC is not aware of which trusts provide/offer private services for CYP then this information should be part of the information request form to the trust that informs the datapack.

### Long Term

- A modular approach is needed to the inspection of CYP services taking elements from the acute, community and mental health models as required for a single provider.
- CQC should consider whether inspection of **children's hospices** might sit better under the portfolio of the Chief Inspector of General Practice or the Chief Inspector of Hospitals.

## 10. Conclusions

### Key Points

- There needs to be a figurehead within CQC to lead on the CYP agenda.
- The recommendations in this report are pragmatic rather than aspirational so that they can be realistically delivered by CQC.

- 10.1. To drive the children & young people (CYP) agenda forward and to ensure that the recommendations in this report are implemented there will need to be clear ownership and leadership of the CYP agenda within CQC. Whilst CQC has a dedicated children's inspection team that brings a wealth of day to day experience of issues relating to safeguarding, there are no clinical advisors in CQC for CYP (either general or specialist) and no senior leader in this area. These are gaps that need to be filled.
- 10.2. CQC has announced the appointment of four Deputy Chief Inspectors (DCIs) to support the Chief Inspector of Hospitals. One of these is for mental health and has CAMHS within his remit. It is recommended that CQC appoints a national professional advisor (NPA) for CAMHS to support the on-going development and implementation of CAMHS inspection within the mental health model and ensure links are made to the acute and community inspection programmes.
- 10.3. I am not aware of plans for a DCI to have overall responsibility for CYP and I recommend that this is an area included within the portfolio of one of the new DCIs. I recognise that DCIs have not been appointed to lead on particular '*client groups*' (with the exception of mental health) but there needs to be a figurehead to ensure that the recommendations in this report are considered and implemented and to drive improvement in this area more generally. This DCI needs to be supported by two national professional advisors (a paediatrician and a children's nurse – one focusing on acute and the other community services). They need to drive forward the day to day development and implementation of this agenda for the acute and community trusts making appropriate links to mental health and primary care where necessary.
- 10.4. The advice in this report has been structured around the CQC inspection process, domains and KLOEs to make it as easy as possible for CQC staff to lift the recommendations and advice and slot them into the developing models. In doing so, the CYP community may find it hard to see how themes that are of particular interest to them such as the deteriorating child, shared care, transition etc are addressed. These issues are covered but spread throughout the report. When the NPAs are in post, I recommend that they consider producing some factsheets for key CYP related themes that show how they are being addressed as part of the inspection programme, for example, what information is in the datapack and what KLOE prompts are being used so that it is clear that individual elements of CYP services are being adequately addressed. This will also be useful if CQC is called in to consider concerns about a particular issue in a trust.

10.5. My overall remit was to advise on how the CQC could make its acute and specialist hospital inspection methodology fit for purpose for CYP and to make initial links with the other developing programmes. I have achieved this and taken steps to enable CQC to pilot the modified methodology in two specialist children's trusts in May. It will be important to learn the lessons from these pilots and enhance the methodology further if needed.

10.6. This is a pragmatic rather than an aspirational report focusing on what CQC can realistically be expected to deliver. As a result, I hope that CQC will accept and implement my recommendations. If they do, the CQC inspection programme should be more credible to the CYP community than it currently is (although there will still be more to do) and, more importantly, should play an important role in driving improvement in CYP services in England.

### **Summary of Recommendations**

#### *Short Term*

- A DCI within the hospital inspection directorate is given overarching responsibility for the CYP agenda.

#### *Medium Term*

- The lead DCI is supported by 3 NPAs – a paediatrician and a children's nurse to cover acute and community services and a CAMHS expert to support the DCI for mental health.

#### *Long Term*

- Factsheets for CYP related themes (e.g. the deteriorating child, shared care and transition to adult services) need to be produced showing how they are being addressed by the inspection process.

## Summary of Recommendations

This section lists in one place the recommendations that appear throughout the report. They are grouped according to the chapter they appear in and whether they should be implemented in the short term (i.e. for Q1 inspections) or in the medium to longer term. For some of the related detail you will need to refer to the relevant section of the report.

### Pre-hospital Inspection preparation

#### *Short term*

1. The Intelligent Monitoring Tool (IMT) should include a breakdown of the current indicator collection by age showing CYP data separately in age bands (0-1, 1-17, 18-25).
2. A CYP specific supplement to the inspection datapack is needed based on quantitative and qualitative information set out in **Annex E**.
3. Feedback should be sought from a range of stakeholders and built into the datapack so that the chair and inspection team have an opportunity to consider this information ahead of the inspection and use it to inform the inspection. These stakeholders should be asked for feedback on specific issues as set out in **para 4.21**.

#### *Medium term*

4. The following indicators should be prioritised for inclusion within the IMT for CYP: CYP/parent/staff confidence in CYP services; existing mortality indicators by age; never events involving CYP; SUIs (including SCRs) involving CYP; NRLS data; nurse sickness, turnover and stability rates; and agency rates.
5. CQC's surveillance team should build the subset of the CYP's Health Outcomes Forum's indicators and outcomes identified in **Annex D** into the IMT as a matter of priority. Where these indicators/outcomes are not appropriate for use in the IMT (as either tier 1 or tier 2 indicators) then they should be included within the CYP datapack as a minimum to inform key lines of enquiry (KLOEs).
6. The results of the new CYP inpatient survey should be built into the IMT and datapack once available.
7. CQC should work with the '*organisers*' of all audits it uses to identify an '*accepted*' range/benchmarks (if there is not one set already) to help inspectors identify potential outliers etc and includes this in the IMT and/or datapack.

#### *Longer term*

8. CQC should work with stakeholders to develop the indicators/outcomes recommended by the Forum that need a new data source or adaptation to an existing data source.
9. CQC should fund the inpatient survey for CYP and parents as an annual survey.
10. CQC should use 5 year age bands for data.
11. Intelligence directorate should continue its dialogue with specialist children's services to ensure that the IMT is more robust in terms of consideration of CYP services than is currently the case.
12. If CQC wishes to use an overarching clinical dashboard for CYP services, it should commission a piece of work to produce this in collaboration with key professional bodies.

### Involvement of CYP & Parents

#### *Short term*

13. Include parents in all acute and specialist trusts inspections if possible but, as an absolute minimum, include at least 2 (preferably 4) parents on the inspection team of specialist children's trusts and large tertiary providers.

14. Analyse a sample of complaints from the previous 3-6 months related to CYP services at the trust.
15. Ensure publicity for the existing acute trust listening events emphasise that parents are welcome.
16. Interview CYP and parents who are on wards, attending outpatient clinics and at A&E during the inspections – these interviews should be conducted by members of the inspection team allocated to inspecting services for CYP.
17. Ask trusts as part of the KLOEs if and how they use modern technologies to seek inpatient feedback from CYP.
18. Hold a listening event aimed specifically at parents and carers [**specialist children's hospitals/large tertiary providers only**].
19. Hold a focus group (outside of school time) with members of the children's council (or equivalent) [**specialist children's hospitals/large tertiary providers only**].
20. Arrange a bespoke engagement activity for parents ahead of inspection of the 2 specialist children's trusts pilots. [**specialist children's hospitals only in the first instance**].

#### *Medium term*

21. Introduce parents as a specific cohort of the 'experts by experience' programme.
22. Train parental experts-by-experience to interview CYP and parents during inspections.
23. Enhance CQC's profile through social media such as YouTube, Facebook and Twitter.
24. Encourage young adults (19 and over) to take part in inspections.
25. Work with Healthwatch to strengthen the voice parents and CYP.

#### *Longer term*

26. Develop more social media friendly listening events which might be more appealing to young adults.
27. Fund an annual in-patient questionnaire for CYP and parents.
28. Encourage feedback from CYP using mobile technologies.

### **Site Visit**

#### *Short Term*

29. A flexible approach to inspecting CYP services will be needed on acute inspections. The CYP sub team needs to consider how it works with the other core service teams to ensure that issues related to CYP are adequately addressed across the pathway ( from A&E to EOLC). As a minimum, all 'adult' core service sub teams (excluding maternity) need to ask about transition to adult services and comment on this in their section of the trust report.
30. The acute inspection team should always include a doctor who has completed training in paediatrics and a children's nurse. A parent of a child that has used health services should be an expert by experience on the team if possible.
31. Inspection of specialist children's hospitals/large tertiary providers need to include the clinical experts listed at **para 6.10** plus at least two (ideally four) parents of children who have experience of the health service.
32. Pharmacists on the acute team should ask specific questions in relation to medicines managements in relation to CYP – a paediatric pharmacist should be on inspection team for specialist children's trusts and large tertiary children's services.
33. CYP services should always be visited at night – if this cannot be scheduled during the announced visit then it should be part of the out of hours unannounced inspection.
34. Case note tracking should be used during the inspection to follow the pathways of a number of children during the inspection period.
35. The areas listed at **para 6.16** should always be included as part of the inspection.

36. The people listed at **paras 6.21-6.22** should always be interviewed as part of the inspection.
37. The list of CYP specific prompts for generic KLOEs should be shared with inspection teams in advance and used during the inspection to ensure consistency of approach – if the KLOEs change then these prompts should be built into the new KLOEs.
38. A visit to a sample of satellite and/or outreach services should be arranged by exception if there are concerns.

#### *Medium term*

39. CYP sub team leaders need background knowledge and experience of inspecting CYP services – the CQC Academy should introduce a programme to develop CQC inspectors in this area.
40. Young people (over 19s) with experience of hospital should be encouraged to take part in inspections.

#### *Long term*

41. The description of '*what good looks like*' for CYP services should be developed further and kept under review by the NPAs recommended in **section 10** working with the RCPCH and affiliated speciality groups.

### **Additional considerations for specialist trusts & large tertiary providers**

#### *Short term*

42. Inspection of specialist children's hospital/large tertiary providers need to include the clinical experts listed at **para 6.10** plus at least two (preferably four) parents of children who have experience of the health service.
43. The eight core services for specialist children's trusts and large tertiary providers should be A&E, medicine, surgery, critical care, neonatal services, adolescent & transition services, palliative & end of life care and outpatients.
44. A sample of the 41 specialised health services relevant to CYP should be chosen for inspection (based on audit data, stakeholder feedback, plus two chosen at random) and inspected as part of the most appropriate core service – the focus should be on system and process rather than specific clinical expertise.
45. Nationally commissioned specialised CYP services should be inspected by exception i.e. if NHS England highlights concern as part of the CQC pre-inspection information gathering exercise.
46. CYP specific prompts that have been developed to support the KLOEs for the acute inspection model should also be used for specialist children's trusts and large tertiary providers with the addition of a small number of additional prompts in the safe, effective and responsive domains, for example, related to shared care.

#### *Medium term*

47. Large tertiary providers of CYP services should be inspected in the same way as the standalone specialist children's trusts.
48. CQC should work with BLISS to develop its inspection of neonatal services.
49. The non-child specific standalone specialist trusts should be assessed in the same way as the CYP services within the acute hospital inspection model with an appropriate specialist paediatrician and/or specialist children's nurse included on the team for larger services. A neonatologist and a neonatal nurse should be included on the inspection team for the two specialist women's trusts.

## Report & Quality Summit

### Short term

50. Information about the CYP inspection should go into a single section of an acute trust inspection report but there should be appropriate cross references to the other sections of the report.
51. CYP services should be rated as a whole, taking into account all the core services with the exception of A&E which should be rated with adult A&E to provide a single A&E rating for acute trusts.
52. The report for the Specialist Children's Trusts should be structured around the 8 core services recommended at **para 8.5** with a rating provided for each of these services which would aggregate up to a trust rating.
53. The Quality Summit for specialist children's trusts and large tertiary providers does not need to differ from those for acute trusts.

### Medium term

54. Large tertiary providers will need to be rated against 7 of the 8 acute core services (excluding general CYP services) with a separate rating grid for CYP in line with that used for specialist children's trusts.

## Links to other Programmes

### Short Term

55. CQC analysts work with stakeholders to finalise what the datapack should include for **CAMHS**.
56. CQC policy colleagues involve stakeholders in the development of products such prompts for KLOEs and what good looks like for **CAMHS**.
57. Issues related to **hospital transfers** need to be built into relevant KLOEs.
58. The children's services inspection team need to link across to all CQC inspection models (acute, community, mental health, ambulance and hospices) on **safeguarding** including scheduling of inspections and sharing information and advice as needed.
59. **Children's hospice** inspection teams should include relevant clinical experts.
60. Children under three being treated in standalone **independent sector** hospitals should be regarded as at high risk and a detailed inspection be undertaken with appropriate clinical experts.

### Medium Term

61. The **community** inspection programme needs to comprehensively captures children's services and reflect the importance of pathways of care – appointing a national professional advisor should help with this.
62. The newly appointed Deputy Chief Inspector for **general practice** and Head of General Practice Inspection with CYP in their portfolios need to work with colleagues on the other inspection models to consider the whole pathway for CYP.
63. A **safeguarding** module should be developed for acute and specialist trust inspections to use in hospitals where there has not been a recent single agency safeguarding inspection.
64. CQC's Academy should develop a training module for CQC inspectors who will be responsible for leading inspection in **children's hospices** to ensure they have the necessary knowledge and expertise to lead these teams.
65. The **ambulance service** inspection model must address the needs of CYP as it continues to develop.

66. The clinical side of **children's intensive care transport teams** needs to be inspected as part of the inspection of the 'parent' trust. CQC need to undertake further work on this and use the proposed KLOE prompts in the interim (see paras 9.5 & 9.6).
67. Where an NHS acute or specialist trust provides CYP services on a **private** basis, these should be considered as part of the NHS inspection rather than a second inspection - if the CQC is not aware of which trusts provide/offer private services for CYP then this information should be part of the information request form to the trust that informs the datapack.

#### *Long Term*

68. A modular approach is needed to the inspection of CYP services taking elements from the acute, community and mental health models as required for a single provider.
69. CQC should consider whether inspection of **children's hospices** might sit better under the portfolio of the Chief Inspector of General Practice or the Chief Inspector of Hospitals.

### **Conclusion**

#### *Short Term*

70. A DCI within the hospital inspection directorate is given overarching responsibility for the CYP agenda.

#### *Medium Term*

71. The lead DCI is supported by 3 NPAs – a paediatrician and a children's nurse to cover acute and community services and a CAMHS expert to support the DCI for mental health.

#### *Long Term*

72. Factsheets for CYP related themes (e.g. the deteriorating child, shared care and transition to adult services) need to be produced showing how they are being addressed by the inspection process.

## **Standalone Specialist Children's Trusts and Large Tertiary Children's Services**

### **Standalone specialist children's hospitals:**

- Alder Hey Children's NHSFT
- Birmingham Children's Hospital NHSFT
- Great Ormond Street Hospital for Children NHSFT
- Sheffield Children's NHSFT

### **Large tertiary children's services**

CQC will want to agree a definition to identify the providers that would fall into this category in terms of size and range of specialist services. CQC analysts have started some work that should help with this. Organisations that I would expect to be included within any agreed list, and inspected in the same way as the standalone specialist children's trusts are:

- Addenbrookes Hospital, Cambridge University Hospital NHS FT
- Bristol Royal Hospital for Children (part of University Hospitals Bristol NHSFT)
- Evelina London Children's Hospital (part of Guy's & St Thomas' NHS FT)
- Leeds Children's Hospital (part of the Leeds teaching Hospitals NHS Trust)
- Royal Manchester Children's Hospital (part of Central Manchester University Hospitals NHSFT)
- Great North Children's Hospital (part of the Newcastle upon Tyne Hospitals NHSFT)
- Leicester Royal Infirmary, University Hospitals of Leicester NHS Trust
- Nottingham Children's Hospital (part of Nottingham University Hospitals NHS Trust)
- Oxford Children's Hospital (part of Oxford University Hospitals NHS Trust)
- Royal London hospital, Bart Health NHS Trusts
- Royal Alexandra Children's Hospital (part of Brighton & Sussex University Hospitals NHS Trust)
- Southampton Children's Hospital (part of University Hospital Southampton NHSFT)
- St Georges Healthcare NHS Trusts
- St Mary's Hospital, Imperial College Healthcare NHS Trust
- Variety Children's Hospital (part of King's College hospital NHSFT)
- Chelsea and Westminster Hospital

## Task & Finish Group Membership

- Dr Sheila Shribman      Senior Clinical Advisor
- Chris Humphrey      Clinical Advisor on children's nursing & community services
- Dr Ted Wozniak      Clinical Advisor on general paediatric services
- Dr Sara Hanna      Clinical Advisor on specialist paediatric services
- Dr Veline L'Esperance      Clinical Advisor on primary care & CYP involvement
- Lynn Davinson      CQC - Children's Services Manager
- Heidi Smoult      CQC - Head of Hospital inspection
- Cheryl Cavanagh      CQC - Office of the Chief Inspector of Hospitals

**Hospital Inspection of CYP services: Stakeholder Event (28 January 2013):  
External Delegates**

Names of delegates have been removed from the published version of this report.

## **Subset of outcomes & indicators recommended by the CYP Health Outcomes Forum that CQC should use as part of acute/specialist trust surveillance & inspection**

### **Safe**

#### Data available

- Incidence of hospital acquired infection: i) MRSA ii) C.Difficile iii) Late onset blood stream infections (BSIs) in children
- Incidence of medication errors causing serious harm
- Incidence of harm to children and young people due to "*failure to monitor*"
- Number of SUIs reported (physical and mental health)
- Admission of full-term babies to neonatal care
- Emergency admissions of home births and re-admissions to hospital of babies within 14 days of being born, per 1000 live births
- Hospital admission and A&E attendances for accidental and unintended injuries and non-accidental neglect and maltreatment in CYP

#### New data source or adaptation of an existing data source required

- Number of unexpected cardiac arrests for CYP in hospital
- Paediatric Early Warning System in place and being acted on for CYP

### **Effective**

#### Data available

- Neonatal mortality
- Infant mortality
- Childhood mortality incl for specific conditions (meningococcal, septicaemia, asthma, LRTIs, diabetes and epilepsy)
- Unplanned hospitalisation for children and young people with asthma, diabetes and epilepsy
- A&E attendance rates and unplanned rates of hospitalisation for constipation and urinary tract infections
- Emergency readmissions within 48 hours of discharge from hospital for children and young people
- Emergency admissions for children and young people with lower respiratory tract infections (LRTI)
- % of admitted children and young people with a LoS of less than 24 hours
- Average LoS in hospital for CYP
- Day case rates for certain procedures (to be determined)
- Disability-free survival at 2 years of age for babies born at <30 weeks of gestation
- Trauma - Time from decision made to transfer of a child from Trauma unit to major treatment centre
- Trauma - Time from arrival in Emergency Department to receive CT scan for infants, children and young people with serious head injury
- Emergency Department Attendances for CYP defined by age
- Diabetes - Proof of HbA1C audit with % HbA1c above the agreed standards

- Diabetes - Percentage of patients diagnosed with diabetes who are later admitted due to Diabetic Ketoacidosis (DKA)
- Diabetes - % of patients with diabetes being discussed at a local MDT in the past year
- Diabetes - % of patients with Type 1 diabetes screened for secondary conditions on a timescale in accordance with NICE guidelines
- Breast feeding initiation (in relation to neonatal units)
- Breastfeeding prevalence at 6-8 weeks (in relation to neonatal units)

*New data source or adaptation of an existing data source required*

- Time from presentation at NHS setting to definitive diagnosis – using 18 week data by age as a proxy
- Measure of functional recovery 1-2 years after discharge from PICU for children and young people with traumatic brain injury

**Caring**

*New data source or adaptation of an existing data source required*

- % of CYP who report that their pain was managed

**Responsive**

*Data available*

- Children and young people continue to receive the care they need following transfer from paediatric services

*New data source or adaptation of an existing data source required*

- Rates of admission to age inappropriate environments for children and young people
- EOLC - Numbers of CYP with end of life plans who die in the place of their choice
- Pupil absence in CYP with: long-term conditions; diabetes; disabilities; mental health problems; and looked after children (LAC)

## Recommended content for the CYP datapack

The following is the recommended content for the pre-inspection datapacks. Where this information is not currently available at a national level it should be requested from the trust in the interim. We have organised this information around the five CQC domains although some of the items could arguably appear in more than one domain. The Outcomes & Indicators listed in Annex E should be built into the datapack as they become available.

### Context

#### *General*

- Health profile for local area compared to rest of England for CYP related indicators:
  - deprivation
  - proportion of children in poverty
  - smoking in pregnancy
  - starting breast feeding
  - obese children (year 6)
  - alcohol specific hospital stays (under 18s)
  - teenage pregnancy (under 18s)
  - infant deaths

#### *Trust Specific*

- A list of all areas in the hospital where CYP might be seen and treated. Some of these will be CYP specific, some areas where both CYP and adults are seen and treated and some may be predominantly adult environments where CYP might be seen on occasion.
- A summary of the services (including related facilities e.g. no. of beds/cubicles) that are provided for CYP by the trust covering:
  - Neonatal care
  - A&E/Emergency services
  - Children's assessment unit
  - Day care unit(s)
  - Inpatient services (including a summary of what these services are and highlighting those that are specialist/shared care)
  - Outpatient services (including a summary of what these services are and highlighting those that are specialist/shared care)
- Organogram of the CYP service leadership team

#### *Stakeholder Feedback*

- A summary of the feedback received from:
  - referring trusts and trusts where there are significant shared care/network arrangements
  - NHS England and CCGs
  - hosts of satellite and/or outreach services
  - local CAMHS
  - the Royal College of Paediatrics & Child Health (RCPCH) and Royal College of Nursing (RCN)
  - Child Death Overview Panel (CDOP)
  - CQC's Children's Services Inspection Team

## Safe

- Medical, nursing and play staff numbers
- Never Events involving CYP
- Serious Untoward Incidents involving CYP
- Reports to NRLS re moderate and above incidents involving CYP
- Medication errors for CYP services
- Infection control data for CYP services (MRSA, MSSA and C. Difficile) separated out for neonates and CYP if possible
- Bed Occupancy in CYP
- Adherence to Safeguarding Children's Standards produced by the College of Emergency Medicine's Clinical Effectiveness Committee:
  - All Emergency Department medical and nursing staff should, as a minimum, have level 2 Child Protection training. All senior EM doctors (ST4 or equivalent and above) should have level 3 Child Protection training.
  - Emergency Departments should have access to a senior Paediatric and senior EM opinion 24 hours a day for child welfare issues.
  - Emergency Departments should have an IT system, which identifies previous attendances in the last 12 months, which is visible on ED notes.
  - Emergency Departments should notify the local Safeguarding Children Services (as per local guidelines) of all children who have attended more than 3 times in the past year with different conditions within 5 days of the most recent attendance.
  - Emergency Departments should notify all child ED attendances (<16 years) to both the GP and the Health Visitor/School Nurse (or other appropriate service as per local guidelines), giving the date and the diagnosis as a minimum.
  - Skull or long bone fractures in children < 1 year old should be discussed with senior Paediatric or senior EM doctor during their ED attendance.
  - Emergency Departments should document on ED notes whether or not patients <16 years of age have a named social worker.
- Safeguarding training rates and board report

## Effective

- Table summarising which of the 14 National Clinical Audits/Confidential Enquiries (recommended by DH) the trust participates in:
  - Child Health programme(CHR-UK)
  - Paediatric Cardiac Surgery
  - Paediatric Diabetic Audits
  - Paediatric IBD inpatient care audit
  - Epilepsy 12 audit
  - Paediatric Intensive Care (PICANet) audit\*
  - Neonatal Intensive and special care
  - Paediatric bronchiectasis (British Thoracic Society)
  - Paediatric asthma (British Thoracic Society)
  - Paediatric pneumonia (British Thoracic Society)
  - Paediatric Fever (College of Emergency Medicine)
  - Maternal, infant and new born programme (MBRRACE-UK)
  - Patient Outcome and death (NCEPOD)
  - Pain database

Note\*: Indicators from the PICANet audit that should be used are:

- standardised mortality by unit
  - 48hr readmission by unit
  - 30 day outcome by unit
  - refusal as no beds or no transport.
  - during normal working hours one medical trainee or equivalent grade doctor should not normally be allocated more than five patients.
  - outside normal working hours, for every eight PICU beds there should be at least one ST4 or above grade doctor available to the unit at all times
  - the unit's nursing establishment and nursing rosters should be appropriate to the anticipated number and dependency of patients. Staffing levels should be based on the ratios advised in Appendix 13 of the audit
  - all nurses should have up to date paediatric resuscitation training. Senior nurses should have up to date advanced paediatric resuscitation training.
- Performance against all adult indicators (or key ones identified in collaboration with stakeholders) from each of the 14 National Clinical Audits/Confidential Enquiries. ***For each indicator included in the pack it will be important to agree with the audit organiser and relevant stakeholders an appropriate benchmark (if there is not one set already) to help inspectors identify potential outliers etc. It is recognised that this may take some time but work should commence on this.***
  - Adherence to NICE Quality Standards:
    - QS4 Specialist neonatal care
    - QS27 The epilepsies in CYP
    - QS36 Unitary tract infections in infants, CYP under 16
    - QS42 Headaches in young people and adults
    - QS44 atopic eczema in children

- Adherence to NICE clinical guidelines:
  - CG54 Urinary tract infection in children
  - CG57 Atopic eczema in children
  - CG84 Diarrhoea and vomiting in children under 5
  - CG89 When to suspect child maltreatment
  - CG99 Constipation in children and young people
  - CG109 Transient loss of consciousness in adults and young people
  - CG111 Nocturnal enuresis - the management of bedwetting in children and young people
  - CG112 Sedation in children and young people
  - CG116 Food allergy in children and young people
  - CG128 Autism in children and young people
  - CG145 Spasticity in children and young people
  - CG149 Antibiotics for early-onset neonatal infection
  - CG160 Feverish illness in children
  - CG170 Autism - management of autism in children and young people
  
- Adherence to RCPCH standards for acute paediatric services:
  1. Every CYP who is admitted to a paediatric department with an acute medical problem is seen by a MG or consultant within 4 hours of admission.
  2. Every CYP who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent) within the first 24 hours.
  3. Every CYP with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the MG rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.
  4. All Short Stay Paediatric Assessment Units have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
  5. At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).
  6. A paediatric consultant (or equivalent) is present in the hospital during times of peak activity
  7. All general paediatric inpatient units adopt an attending consultant system, most often in the form of the 'consultant of the week' system.
  8. All general acute paediatric rotas are made up of at least 10 wte (all EWTD compliant)
  9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.
  
- Composite indicator: in-hospital mortality (paediatric & congenital disorders & perinatal mortality).
  
- Maternity outlier alert: Neonatal Readmissions.
  
- Readmission rates at 48 hours for paediatric services including heat map for paediatric-related services (A&E, surgery, trauma & orthopaedics etc) for 1-17s.
  
- Multiple admissions (eg. 2+ in 6-12 months) in CYP (1-17) with long term conditions (including a breakdown for asthma, epilepsy and diabetes).
  
- Comparison between five most common conditions/symptoms that can cause CYP to present to emergency and urgent care nationally to the trust's most common inpatient admissions ie. inpatient paediatric treatment specialty attendances vs NHS average
  
- Cancelled ops for CYP
  
- Length of stay for CYP
  
- Findings from latest CYP peer reviews e.g. child & adolescent cancer services and paediatric diabetes.

## **Caring**

- Results of any local trust in and out patient experience surveys for CYP services (A&E and wards).
- Cancer Patient Experience Survey – results for the 16-25 age group
- National CYP trust inpatient survey results [*Note: expected to be available from early 2015 – this is expected to provide experience for 0-7s, 8-12s, 13-17 and parents*]

## **Responsive**

- A&E Attendance by age groups (0-1 and 1-17 as a minimum)
- A&E waiting times for 0-1s and 1-17s
- % of CYP seen within 4 hours for 0-1s and 1-17s
- Average length of time in Children's Assessment Unit (CAU) for 0-1s and 1-17s

## **Well-led**

- Breakdown of complaints/PALS data for CYP service
- Staff survey results for CYP services.
- Trust's own CYP dashboard (if there is one)
- GMC National Training Scheme Survey 2013 – paediatrics
- Table summarising which of the following CYP specific accreditation schemes (or equivalent) the trust participates in from:
  - Your Welcome, DH's '*Quality criteria for young people friendly health services*'
  - Bliss Family Friendly Accreditation Scheme
  - Unicef's Baby Friendly accreditation

**CYP & Parent Focus Groups: Views on 'What Good looks like'**

1. Delegates at the focus groups arranged by the CQC and the RCPCH considered the attributes that are essential for a good health service for children & young people (CYP) within the context of CQC's 5 domains: safe, effective, caring, responsive and well-led. A summary of their views follows:

**Safe**

2. Within the safe domain, CYP focused on a clean, safe and secure environment. CYP also wanted their concerns to be taken seriously throughout their journey through the health services; from admission to discharge. Many felt that this was down mainly to good communication between the staff and themselves. Young people felt that a safe service was one that inspires confidence in patients, parents and carers. Furthermore, they felt that allocating enough time to each patient enabled a good relationship to be built on which trust and confidence would provide the basis for good care. Moreover, having the right equipment that was easily accessible was also described as being safe. Parents and carers felt that a safe service was one which encouraged a good level of communication between the school nurse, their GP and the hospital as whole. Parents and carers also agreed that thorough explanation of medication and their dosages was also a key aspect of a safe service. They reiterated that sometimes one explanation just is not enough.

**Effective**

3. CYP from our focus groups felt that an effective service was one in which procedures were explained thoroughly and reassurance was provided in a timely manner. A proactive approach was also viewed as key to an effective service. CYP also described an effective service as one which empowers them to take ownership of their own health. However, they noted that for this to happen they must be provided with all the information to make these decisions and therefore steps should be taken to ensure that patients feel supported both in their illness and their recovery. Parents and carers expressed that an effective service was one that allowed sub-specialists to be easily accessible either face to face or via mobile technology at smaller units. Furthermore, they felt that an effective service was one that enabled them to be seen closer to home.

**Caring**

4. CYP felt that caring meant being fully informed and being able to contribute in the decision making process about their care. A caring approach was also viewed as child-friendly and personalised care. Within this domain a caring service was one which supported them through the transition process. CYP and their parents and carers wanted to feel supported to manage their condition. Polite and friendly staff who provided explanations clearly and concisely were also viewed as caring. Provision of healthy food with various options was also seen as being caring. This view was also one expressed by the parents and carers. A caring service was viewed as one which provided intellectually stimulating activities for CYP of all ages and capabilities.

## **Responsive**

5. A key theme from the responsive domain was a service that specifically catered for needs of CYP within that community. An example was provision of adolescent wards and designated areas for teenagers. Many spoke about transition as a key feature of a responsive service. Furthermore, CYP were adamant that a responsive service was one in which ideally all members of the multidisciplinary team involved in paediatric care should be readily available in emergency situations. This team-based approach was viewed by many CYP as the best way to allow for a seamless transition from hospital care to community care and vice versa. It was highlighted that in circumstances of repeated admissions, a clinician familiar with their care should, where possible, be available to provide input to the admitting team. It was felt that paediatric care should be age appropriate. For example, teenagers should not be admitted to an adult medical/surgical ward nor should they find themselves on a paediatric ward with a "playroom" that only caters for the under fives. Of note, in communities where English is not a first language of the residents, interpreters should be available either in person or via the telephone. Open and honest dialogue when mistakes were made was viewed as a responsive service. Parents and carers also mentioned that a responsive service was one which took the needs of hearing and visually impaired CYP into consideration.

## **Well led**

6. A well-led service was described by the CYP as one in which there were clear lines of communication and there was not conflicting information. Furthermore it was acknowledged as one which was able to learn from its mistakes. Most importantly a well-led service was described as one which other children's hospitals globally could learn from. Parents and carers explained that a well-led service was one in which those very senior in the organisation also knew the key issues affecting front-line staff.

## CYP Prompts for Generic KLOEs (by CQC Domain)

This annex sets out CYP related prompts relevant to the Generic KLOEs that were developed for the Wave 2 acute hospital inspections. They cover general hospital, general & emergency CYP and specialist CYP issues. Some prompts could appear under multiple KLOEs. It does not matter which KLOE they appear under as long as they are asked. If the KLOEs are revised then the prompts need to be reallocated to the new KLOEs. As data on some of these issues becomes available in the datapack then some of these prompts only need to be raised by exception.

### Safe

#### S1: How **safe** has care been in the **past** (based on performance data)?

- What is your track record on:
  - Never events in 0-17s
  - Serious incidents in 0-17s
  - Infections rates in 0-17s
  - Medication errors in 0-17s

#### S2: How well has the provider **learnt** when things go wrong and **improved** safety standards as a result?

- Are you aware of any never events/SUIs that have involved CYP within the trust and, if so, what was the learning from them?
- What is the frequency of medication errors related to CYP and what systems have been introduced to minimise these? What changes have been made as a result of any such errors?
- Have there been any RCPCH invited reviews? If so, what were they about and how have they been responded to?
- What examples are there of the organisation responding to findings in a coroner's reports relating to a CYP death?

#### S3: Are there **reliable systems, processes and practices** in place to keep people safe?

- Are there up-to-date standard operating procedures in place specifically for services for CYP?
- Have you implemented the 2013 Royal College of Nursing guidance on staffing and the general acute paediatric rotas (at least ten WTEs doctors all of whom are EWTD compliant)? When was this last reviewed and what patient acuity and workload measures are used?
- Is there a reliance on shift rotas/ bank /agency staff in CYP services – do bank/locum staff have appropriate paediatric training?
- What arrangements are in place for the transfer of CYP between specialist and acute trusts e.g. managing CYP who develop complications during their stay?

- Roughly how many CYP have to be transferred from A&E to other hospitals a week/month etc, what is the general cause?
- Do trusts with emergency services for CYP and in-patient beds:
  - monitor the number of secondary care transfers due to lack of beds;
  - treat each transfer due to lack of beds as a critical incident;
  - present data on this regularly to the executive board as part of the children's governance report?
- Do trusts with emergency services for CYP without inpatient beds:
  - have robust plans in place for secondary transfer that are agreed with the local ambulance provider;
  - are these plans monitored and reviewed in regular joint governance meetings between hospital and ambulance trusts?
- Do you use a paediatric specific safety thermometer (or equivalent)?
- How does the trust educate CYP on infection control practice?
- How are controlled drugs for CYP managed [look at the control drugs book for correct documentation]?
- Do you have a system of clinical supervision in place for nurses in CYP services?
- Do CYP requiring emergency surgery have access to theatre within a reasonable timescales (<12 hours)?
- Are you meeting the Safeguarding Children's Standards \* produced by the College of Emergency Medicine's Clinical Effectiveness Committee \*? How are you addressing any unmet standards?  
**[Note – when this information is available in the data pack then questions can be raised by exception i.e. for those areas where the standards are not met]**

\* Safeguarding Children's Standards produced by the Clinical Effectiveness Committee of the College of Emergency Medicine:

- All Emergency Department medical and nursing staff should, as a minimum, have level 2 Child Protection training. All senior EM doctors (ST4 or equivalent and above) should have level 3 Child Protection training.
  - Emergency Departments should have access to a senior Paediatric and senior EM opinion 24 hours a day for child welfare issues.
  - Emergency Departments should have an IT system, which identifies previous attendances in the last 12 months, which is visible on ED notes.
  - Emergency Departments should notify the local Safeguarding Children Services (as per local guidelines) of all children who have attended more than 3 times in the past year with different conditions within 5 days of the most recent attendance.
  - Emergency Departments should notify all child ED attendances (<16 years) to both the GP and the Health Visitor/School Nurse (or other appropriate service as per local guidelines), giving the date and the diagnosis as a minimum.
  - Skull or long bone fractures in children < 1 year old should be discussed with senior Paediatric or senior EM doctor during their ED attendance.
  - Emergency Departments should document on ED notes whether or not patients <16 years of age have a named social worker.
- What wider safeguarding protocol/guidance is in place - how are safeguarding issues talked about, who manages them, are lessons learned etc?
  - Do you have a system to check whether all children are subject to a child protection plan?

**S4: How does the provider monitor safety in real-time and react appropriately to changes in risk level, including at an individual patient level?**

- Is the environment safe for CYP eg: secure/monitored entrance, staff awareness/protocols in place for restricted visitors, protocols in place if there are CYP with safeguarding concerns on the ward, medication cupboards kept locked, play areas (incl toys/games) cleaned regularly etc?
- What system is in place to recognise and respond to the deteriorating child (e.g. is Paediatric Early Warning Score or equivalent in place) – how is it used, if it is triggered what escalation protocol is in place, how are staff trained to use it?
- What are your handover arrangements on CYP wards?
- How do you monitor how long children spend in the Children’s Assessment Unit before either admission or discharge?
- How do you access specialist paediatric advice – how does this differ out of hours – do you feel the service is safe for CYP out of hours including evenings and weekends?
- How often are high dependency CYP (ie those that need HDU) cared for on the wards? Where does this take place and what is the nurse to child ratio for these patients?
- How often does bed occupancy in CYP services rise above 85%? Do you often have problems finding beds for CYP who need to be admitted? What action do you take?

**S5: How well are problems anticipated and planned for in advance?**

- How does your trust winter management plan meet the needs of CYP (eg. to cover bronchiolitis season)?
- How does your trust summer management plans meet the needs of CYP (especially those trusts near the coast)?

## Effective

### E1: Is care and treatment delivered in line with current legislation, standards and nationally / internationally recognised **evidence-based** guidance?

- Do you adhere to the following RCPCH standards\* for acute paediatric services – how is this monitored? How are you addressing any unmet standards? **[Note – when this information is available in the data pack then questions can be raised by exception i.e. for those areas where the standards are not met]**

\*RCPCH standards for acute paediatric services (see RCPCH document for full wording):

1. Every CYP who is admitted to a paediatric department with an acute medical problem is seen by a MG or consultant within 4 hours of admission.
2. Every CYP who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent) within the first 24 hours.
3. Every CYP with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the MG rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.
4. All Short Stay Paediatric Assessment Units have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
5. At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).
6. A paediatric consultant (or equivalent) is present in the hospital during times of peak activity
7. All general paediatric inpatient units adopt an attending consultant system, most often in the form of the 'consultant of the week' system.
8. All general acute paediatric rotas are made up of at least 10 wte (all EWTD compliant)
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

Note:  
1-7 - should be met by all in-patient units  
3,4 & 6 - should be met by all standalone short stay units  
1-9 - should be met by all specialist trusts

- Do you adhere to the following RCN standards\* for staffing levels in CYP services: – how is this monitored? How are you addressing any unmet standards? **[Note – when this information is available in the data pack then questions can be raised by exception i.e. for those areas where the standards are not met only]**

\*RCN standards:

- minimum of 70:30 per cent registered to unregistered staff with a higher proportion of registered nurses in areas such as children's intensive care, specialist wards. For example,  
Neonatal (registered nurse : infant)
  - o special care 1:4
  - o High dependency care 1:2
  - o Intensive care 1:1PICU and HDU (registered nurse : patient)
  - o Level 1: 0.5:1
  - o Level 2: 1:1
  - o Level 3: 1.5:1
  - o Level 4: 2:1
- minimum of two registered children's nurses at all times in all inpatient and day care areas.
- number of students on a shift should not exceed that agreed with the university for individual clinical areas.
- access to a senior children's nurse for advice at all times throughout the 24 hour period.
- at least one nurse per shift in each clinical area (ward/department) trained in APLS/EPLS (advanced or European paediatric life support) depending on the service need.

- For specialist children's trusts and large tertiary providers, what evidence is there of compliance with National Specialised Service Specifications for specialised paediatric services, what derogations with plans and timeframes to be fully compliant?

**E2: How do the outcomes for this provider compare with those of similar providers? How well are they being monitored and improved?**

- How do your National Clinical Audits/Confidential Enquiries\* results compare with others comparable providers – what action are you taking in response to findings?

\* National Clinical Audits/Confidential Enquiries\*recommended by DH:

- Child Health programme(CHR-UK)
  - Paediatric Cardiac Surgery
  - Paediatric Diabetic Audits
  - Paediatric IBD inpatient care audit
  - Epilepsy 12 audit
  - PICANet
  - Neonatal Intensive and special care
  - Paediatric bronchiectasis (British Thoracic Society)
  - Paediatric asthma (British Thoracic Society)
  - Paediatric pneumonia (British Thoracic Society)
  - Paediatric Fever (College of Emergency Medicine)
  - Maternal, infant and newborn programme (MBRRACE-UK)
  - Patient Outcome and death (NCEPOD)
  - Pain database
- Are there any of these audits/enquiries that are relevant to your services that you are not participating in? If so, which ones and why and how do you assess effectiveness of services in these areas?
  - How do your surgery results compare with national benchmarks such as Dendrite and BAPS audits? Are there regular audit meetings to compare results –provide an example of actions taken as a result?

**E3: How does the provider make sure that staff (including skill mix), equipment and facilities enable the effective delivery of care and treatment, which does not impact on quality?**

*Staff*

- What evidence is there that trust training applies to CYP?
- What are your safeguarding training rates – are all staff up to date for levels 1, 2 and 3?
- Do all anaesthetists/theatre/recovery staff who may care for CYP have up-to-date competencies in paediatrics?

*Equipment*

- Is there paediatric specific resuscitation equipment easily accessible for staff in all areas where CYP will be seen and treated, is it maintained, are staff in these areas aware where to find this? [Note: this should also be asked by some other core service sub teams e.g. A&E and surgery]
- Is paediatric specific surgical equipment (eg. for bronchoscopy) available in shared theatres and is it maintained. [Note: this should also be asked by some other core service sub teams e.g. surgery]

## Facilities

- Are there paediatric specific recovery bays? If not, how do you manage this? [*Note: this should also be asked by some other core service sub teams e.g. surgery*]
- What percentage of CYP are seen in predominantly adult based areas (eg. outpatients department) - how do you try to accommodate the needs of CYP and parents eg. is there a separate waiting area, is there a play area etc? [*Note: this should also be asked by some other core service sub teams e.g. outpatients*]
- What facilities are available for young people/adults (17-25) who are put on adult wards? [**Note – not relevant to standalone specialist children’s trusts**]

**E4: How does the provider support and enable multi-disciplinary working within and between services across the organisation and with external organisations?**

### *Within the organisation*

- What access to paediatric advice is available for A+E doctors?
- Are there paediatric MDT meetings and ward rounds?
- How do you ensure there is access to paediatric pharmacy advice 24/7?
- What access do you have to CAMHS (embedded in acute vs provided separately) - do you have timely and appropriate access to CAMHS support?
- How satisfied are you with the liaison psychiatry service? What could be better?
- How do adult and CYP services work together to manage transition - what transition services are you particularly concerned about?
- How do you ensure discharge planning meets the needs of CYP with long term or complex conditions?

### *With other organisations*

- For specialist children’s trusts and large tertiary CYP services, what support do you provide to your DGHs ie:
  - giving timely advice;
  - accepting referrals in a timely manner;
  - managing step down/transfer of care back to an acute trust/community when the time is right and supporting acute trusts (or others) to take this on (discharge info etc);
  - supporting secondary care staff to develop specialist competencies as appropriate?
- For specialist children’s trusts and large tertiary services, how do you contribute to relevant specialist networks – what evidence is there of support to networks through education, training and shared protocols e.g. an identifiable network lead for each service and a point of contact for urgent and non-urgent enquiries and referrals?

- For acute trusts:
  - what access do you have to advice from tertiary paediatric services in and out of hours and is this sufficient;
  - what discharge information and support is available when patients are transferred back to your care – is it timely and sufficient?
  
- For acute trusts, how do you:
  - co-ordinate discharges with community services;
  - work with other health (community paediatrics services, CAMHS, GPs, health visitors, practice nurses and midwives etc) and social care providers/social services to meet the needs of CYP in your area;
  - contribute to relevant networks of care (including aspects of paediatric pathology and imaging as well as patient pathways) and relevant shared care arrangements?
  
- Do you adhere to RCPCH standard for acute paediatric services that: *'All CYP, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report'*. How is this monitored?

## Caring

**C1: Are patients made to feel **safe** and **comfortable**, and treated with **compassion, dignity and empathy**, while they receive treatment and personal care?**

- Are there separate areas for children and adolescents - how are the needs of adolescents/young people met?
- Do CYP have the choice of same or mixed sex accommodation?
- Do older children talk to a clinician without a parent present?
- Do you have qualified play specialists available in areas that CYP will be seen and treated eg. wards, outpatient clinics, A+E, radiology etc? Are there any areas where children are seen without access to qualified play specialists? Are play specialists/services available 7 days a week?
- What happens if a CYP needs access to an AHP? Are AHPs available seven days a week?
- Can CYP keep in touch with their friends and family while in the hospital e.g. access to facebook?
- Is anaesthesia/pain relief effective and appropriate?/ Is there an MDT approach to pain management e.g. following paediatric surgery?

**C2: How are patients and those close to them **involved** as '**partners**' in their care – taking part in **informed** decisions about their care, with **support** where needed?**

- Do you provide information and support in a child friendly format to help CYP make decisions about, or agree to, care and treatment (incl. consent/assent)?
- How do you involve CYP and parents in care plans? [Ask parents if their child has a care plan, were they involved in developing it, is it current, do they understand it?]
- How are parents and young people taught the competencies required to provide care at home when necessary and how is this assessed?

**C3: Do staff develop **trusting relationships** and **communicate respectfully** with patients and those close to them, throughout their hospital stay?**

- Are parents confident leaving their child's care with the staff on the ward at the time?

**C4: Do patients and those close to them receive the **support** they need to cope **emotionally** with their treatment and hospital visit/stay?**

- What reasonable adjustments do you make for a CYP that might struggle with the hospital environment?
- Do you have access to child psychologists to support CYP with long term or complex conditions?
- What support is available for parents who have received bad news?

## **Responsive**

**R1: How does the provider plan its services to meet the needs of the different types of people it serves?**

- What engagement and involvement of CYP has there been in the design and running of your services? Do you have a children's and/or a parent's/carer's panel?
- Is there a focus on capturing young adults views through patient experience questionnaires? Is there a young adult forum to support the organisation in making ongoing changes across paediatric and adult services?
- How do you meet the needs of:
  - CYP of a variety of ages
  - CYP with long-term health conditions
  - CYP in receipt of end-of-life care
  - CYP with physical and/or learning disabilities
  - CYP where English is not their and/or their parents first language?
- Are services young people friendly and age and developmentally appropriate? Are there:
  - appropriate facilities and information
  - trained staff
  - clear care plans for young adults with complex needs and rare conditions.
  - trust age policies
  - means to relieve boredom
  - young person involvement/forum?
- Does a CYP seen in a largely adult area have the same experience as a CYP being seen in your CYP only environments? If not, what are you doing to address this?
- For acute trusts, what facilities are available for parents/siblings and relatives eg. accommodation, refreshments etc? [Ask parents if they can stay at their child's bedside – what are the facilities like for sleeping, bathroom, food etc?]
- For specialist children's trusts and large tertiary providers, what accommodation and facilities are available for families travelling large distances from home (e.g. hotel-type services as opposed to hospital facilities)?
- How do pathology services take into account the needs of CYP e.g. appropriate sized blood samples etc?
- Ask staff (particularly those in non-CYP specific areas) how well prepared they feel to work with /communicate with CYP?
- What is your policy/guidelines for children/young people having invasive procedures?
- Are children admitted as day cases wherever feasible?
- How do you ensure that CYP have healthy, appetising and age-appropriate food?

- Is care given as close to the CYP's home as possible/appropriate?

*Note: The hospital school will be registered with OFSTED and does not need to be visited as part of this inspection. However, the latest OFSTED inspection report should be available to the inspection team for context.*

**Note: the adult core service sub-teams (excluding maternity) should ask the following questions:**

- **Is this adult service young person friendly? Does the service have 'You're Welcome' accreditation?**
- **Is this adult service age and developmentally appropriate?**
- **Is it providing "cultural continuity" with the children's service i.e. are there similar practices between the two services to bridge the gap?**

**R2: How does the provider ensure its service meets the needs of patients in vulnerable circumstances or who lack the capacity to communicate their needs?**

- What processes are in place to identify and raise staff awareness of:
  - Children with disabilities
  - CYP with learning difficulties
  - Looked after children
  - Children of asylum seekers
  - Children in need of early help/ children in need
  - Recognition of maltreated children e.g. frequent attendees into A+E, picking up non-accidental injuries (NAIs)?
- What adjustments are made for children with mental health needs requiring acute care, and whose behaviour could be challenging? Can you get input from paediatric liaison and/or CAMHS staff when required? If so, is this service available 24/7?
- How do you involve children and young people in decisions about their health and treatment and gain feedback from them about your services?

**R3: How does the provider make sure that people from all its communities can access its services in a timely fashion?**

- What evidence is there that the CYP service is sensitive to the cultural needs of its community?
- What procedures are in place for CYP with learning disabilities eg. appropriate information for CYP with learning disabilities and their families, training for staff on caring for CYP with a learning disability in A&E etc?
- Ask parents, if the service is responsive to their needs e.g. it easy make appointments/ change appointments etc to avoid term time, school hours etc where possible?

**R4: How does the provider take account of patients' needs and wishes, so they are ready to leave hospital at the right time, when they are well enough and with the right support in place?**

- How do you co-ordinate discharges with community services /How do you ensure discharge planning meets the needs of CYP with long term or complex conditions? Are there discharge planning meetings?

**R5: How does the provider routinely learn from people's experiences, concerns and complaints to improve the quality of care?**

- How do you know what CYP/parents think about the service – how is the CYP/parent voice heard? What action have you taken in response to specific feedback from CYP and parents?
- Do you have a child-friendly format inpatient survey/ friends and family test, suggestion boxes etc /Do you use modern technologies to seek inpatient feedback from CYP (eg Fabio the Frog or equivalent)?
- Does the trust have a breakdown of complaints/feedback broken down by age of patient? Give examples of changes that have been made to the CYP service as a result of a complaints/ feedback?

## Well-led

W1: Is there a clear **vision** and a credible **strategy** to deliver high quality care to patients and are the **risks** to achieving this understood?

- What is the vision for CYP services in this trust? Is everyone aware of this?
- Ask board member(s) how they know what life is like for CYP in their hospital?
- How do you know how your CYP services are performing/ if they are effective? Is there any form of CYP performance/clinical dashboard? How does the trust use the data it produces about CYP services. Is CYP data seen at board and ward levels?
- How are trust's general policies applied to CYP?
- Which accreditation schemes do you participate in (eg. Your Welcome (DH), Baby Friendly (Unicef), BLISS baby charter) and what action have you taken as a result? **[Note – when this information is available in the datapack this can be asked on an exception basis.]**

W2: Do the **governance arrangements** ensure that responsibilities are clear, quality and performance are regularly considered and problems are detected, understood and addressed?

- Is there an Executive and Non-Executive Director lead for CYP?
- Is there a young person on the Board of Governors?
- When did the board last receive a report on safeguarding children?
- What exposure do CYP services get at Board meeting discussions?
- Ask nurses in acute trusts in areas where both adult and CYP can be seen if they know who the most senior nurse in the organisation is for CYP and where they get their senior leadership re CYP from?
- Ask CYP senior managers if they feel an integral part of the organisation?
- What is the relationship between children's A&E and children's wards (if not in the same directorate)?

W3: How do the **leadership** and **culture** within the organisation reflect its vision and values, encourage openness and transparency and promote delivery of high quality care across teams and pathways?

- Do nursing sisters on CYP wards have protected time for this supervisory role?
- Are ward staff engaged in business planning relevant to CYP wards?

**W4: How does the organisation ensure that patients' views and experiences are the key driver for how services are provided, and that staff are involved and engaged?**

- Does the board seek to engage with CYP and staff from CYP services and listen to and understand their voices? Do the governance arrangements support this?
- Are there 'Board Rounds' on CYP wards?
- Ask parents if they know who is in charge of the ward?
- Are CYP involved in developing the hospital?

**W5: How does the organisation strive to continuously learn and improve, support safe innovation, and ensure the future sustainability of high quality care?**

- Do you have any quality improvement programmes for CYP services that have been presented nationally/internationally or have been shortlisted or won any national/ international awards?

## Paediatrics and Child Health Standards & Guidelines

Title	Lead Organisation	Year
<b>General</b>		
<a href="#">A Charter for Paediatricians</a>	Royal College of Paediatrics & Child Health (RCPCH)	2004
<a href="#">Supporting Paediatric Reconfiguration: A framework for standards</a>	RCPCH	2008
<a href="#">Bringing networks to life - An RCPCH guide to implementing clinical networks</a>	RCPCH	2012
<a href="#">Improving services for children in hospital</a>	Healthcare Commission	2007
<b>Acute Care</b>		
<a href="#">Facing the Future</a>	RCPCH	2013
<a href="#">Guidance on the role of the consultant paediatrician in the acute general hospital</a>	RCPCH	2009
<a href="#">Children's and maternity services in 2009: Working Time Solution</a>	RCPCH/RCOG	2009
<a href="#">Solutions for the medical staffing of acute units</a>	RCPCH	2009
<a href="#">Quality and Safety Standards for small and remote paediatric units</a>	RCPCH	2011
<a href="#">Commissioning safe and sustainable specialised paediatric services</a>	DH	2008
<a href="#">Intercollegiate Standards for care of CYP in emergency care settings</a>	RCPCH	2012
<a href="#">The acutely or critically sick or injured child in the district general hospital</a>	DH	2006
<a href="#">Short Stay Paediatric Assessment Units</a>	RCPCH	2009
<b>Child Protection</b>		
<a href="#">Safeguarding Children and Young People: Roles and Competences for Healthcare Staff</a>	Intercollegiate	2010
<a href="#">Peer review in Safeguarding</a>	RCPCH	2012
<a href="#">Working Together to Safeguard Children</a>	HM Government	2013
<a href="#">Child Protection Companion</a> (2 <sup>nd</sup> Edition available for purchase from the RCPCH 2013)	RCPCH	2006
<a href="#">Protecting Children and Young People– responsibilities of all doctors</a>	GMC	2012
<a href="#">When to suspect child maltreatment</a>	NICE	2009
Safeguarding vulnerable people in the reformed NHS – Accountability and Assurance Framework	NHS Commissioning Board	March 2013
Safeguarding children and young people – every nurse's responsibility	RCN	Due

<b>Paediatric Intensive Care</b>		
<a href="#">NHS Standard contract for Paediatric Intensive care</a>	NHSE	2013
<a href="#">Standards for the Care of Critically Ill Children</a>	PICS	2010
<b>Neonates</b>		
<a href="#">Categories of Care</a>	BAPM	2011
<a href="#">Specialist Neonatal Care Quality Standard</a>	NICE	2010
<a href="#">Service standards for hospitals providing neonatal care</a>	BAPM	2010
<a href="#">Toolkit for High Quality Neonatal Services</a>	DH	2009
<a href="#">Matching Knowledge and Skills for QIS Neonatal Nurses</a>	BAPM/RCN	2012
<a href="#">The BLISS Baby Charter and Audit Tool</a>	BLISS	2012
<a href="#">The role of the consultant paediatrician with subspecialty training in paediatric emergency medicine</a>	RCPCH	2008
<a href="#">The Emergency Medicine Operational Handbook</a>	CEM	2011
<a href="#">The Urgent and Emergency Care Clinical Audit Toolkit</a>	RCPCH/CEM/RCGP	2010
<a href="#">Maximising Nursing Skills in Caring for Children in Emergency Departments</a>	RCN	2010
<a href="#">Children's Attendance at a Minor Injury/Illness service</a>	RCPCH	2002
<a href="#">International Standards of Care for Children in Emergency Medicine</a>	IFEM	2012
<a href="#">A service delivery model for urgent care centres: Commissioning advice for PCTs</a>	NHS London	2010
<a href="#">Right care, right place, first time?</a>	RCPCH/CEM/RCGP/ RCN	2011
<b>Surgery</b>		
<a href="#">Standards for Children's Surgery</a>	RCS (Eng)	2013
<a href="#">General paediatric Surgery – Guidance for Commissioners</a>	RCS (Eng)	2010
<a href="#">Surgery for Children: Delivering a First Class Service.</a>	RCS (Eng)	2007
<a href="#">Children/young people in day surgery</a>	RCN	2013
<a href="#">Emergency Surgery Guidance for providers, commissioners and service planners: Standards for Unscheduled surgical care</a>	RCS	2011
<a href="#">Provision of Emergency Paediatric Neurosurgical Services</a>	SBNS and RCOA	2010
<b>Anaesthesia</b>		
<a href="#">Standards for providing Paediatric anaesthesia services</a>	RCOA	2013
<a href="#">Resuscitation training for non-training grade anaesthetists</a>	RCOA	2010
<a href="#">Good Practice in Postoperative and Procedural Pain Management</a>	APAGBI	2012
<a href="#">Fire Safety in Intensive Care and in theatres</a>	RCOA	2013
<b>Imaging</b>		
<a href="#">Delivering Quality Imaging Services for Children</a>	DH	2009
<a href="#">Practice Standards for Imaging children and Young People</a>	SOR	2009
<b>Maternity Services</b>		
<a href="#">Safer Childbirth</a>	RCOG	2007
<a href="#">Standards for Maternity Care - Report of a Working Party</a>	RCOG	2008
<a href="#">Guidance on staffing standards for midwifery</a>	RCM	2009

<b>Involvement and Participation</b>		
<a href="#">You're Welcome Quality Criteria</a>	DH	2011
<a href="#">Not just a phase</a>	RCPCH	2010
<a href="#">Involving Children and Young People in Health Services</a>	RCPCH/ NHS Confed	2011
<a href="#">Patient Reported Experience Measure for urgent and Emergency Care</a>	RCPCH	2012
<a href="#">Exploring the Role and Impact of User Representation and Involvement in Neonatal Network Boards</a>	Warwick University	2008
<b>Transition</b>		
<a href="#">Bridging the Gaps; Healthcare for adolescents</a>	Intercollegiate	2003
<a href="#">Transition – getting it right for young people</a>	DH	2006
<a href="#">Transition – moving on well</a>	DH	2008
<a href="#">Lost in Transition – moving young people between child and adult services</a>	RCN	2013
<b>Palliative Care</b>		
<a href="#">Standards for paediatric palliative care Europe</a>	EAPC	2007
<a href="#">A Core Care Pathway for Children with Life-limiting and Life-threatening Conditions</a>	Together for Short Lives	2013
<b>Nursing standards</b>		
<a href="#">Healthcare service standards in caring for neonates, children and young people</a>	RCN	2011
<a href="#">Standards for assessing measuring and monitoring vital signs in children and young people</a>	RCN	2013
<a href="#">Defining staffing levels for children and young people's services</a>	RCN	2013
<a href="#">Transferring children to and from theatre</a>	RCN	2011
<a href="#">The recognition and Assessment of acute pain in children</a>	RCN	2009
<a href="#">Caring for young people: Guidance for Nursing staff</a>	RCN	2012
<a href="#">RCN Paediatric Nurse Managers' Forum Children in acute independent sector hospitals</a>	RCN	2002
<a href="#">Nurse staffing in children's and young people's health care</a>	RCN	2013
<b>Nice Quality Standards</b>		
<a href="#">Specialist neonatal care (QS4)</a>	NICE	2013
<a href="#">The epilepsies in children and young people (QS27)</a>	NICE	2013
<a href="#">Health and wellbeing of looked-after children and young people (QS31)</a>	NICE	2013
<a href="#">Urinary tract infection in infants, children and young people under 16 (QS36)</a>	NICE	2013
<a href="#">Headaches in young people and adults (QS42)</a>	NICE	2013
<a href="#">QS44 atopic eczema in children (QS44)</a>	NICE	2013
<a href="#">Children and young people with cancer (QS55)</a>	NICE	2013
<a href="#">Neonatal jaundice (QS57)</a>	NICE	2013
<b>NICE Clinical Guidelines</b>		
<a href="#">Urinary tract infection in children (CG54)</a>	NICE	2007
<a href="#">Atopic eczema in children (CG57)</a>	NICE	2007

Diarrhoea and vomiting in children under 5 (CG84)	NICE	2009
When to suspect child maltreatment (CG89)	NICE	2009
Neonatal Jaundice (GC98)	NICE	2010
Constipation in children and young people (CG99)	NICE	2010
Transient loss of consciousness in adults and young people (CG109)	NICE	2010
Nocturnal enuresis - the management of bedwetting in children and young people (CG111)	NICE	2010
Sedation in children and young people (CG112)	NICE	2010
Food allergy in children and young people (CG116)	NICE	2011
Autism in children and young people (CG128)	NICE	2011
Spasticity in children and young people (CG145)	NICE	2012
Antibiotics for early-onset neonatal infection (CG149)	NICE	2012
Feverish illness in children (CG160)	NICE	2013
Autism - management of autism in children and young people (CG170)	NICE	2013

## Paediatrics &amp; Child Health Standards &amp; Guidelines supported by national data

Title	Lead Organisation	Year
<b>General</b>		
<a href="#">Improving services for children in hospital</a>	Health Commission	2007
<b>Acute Care</b>		
<a href="#">Facing the Future</a>	RCPCH	2013
<a href="#">Children's and maternity services in 2009: Working Time Solution</a>	RCPCH/ROOG	2009
<a href="#">Short Stay Paediatric Assessment Units</a>	RCPCH	2009
<b>Paediatric Intensive Care</b>		
<a href="#">NHS Standard contract for Paediatric Intensive care</a>	NHSE	2013
<b>Surgery</b>		
<a href="#">Surgery for Children: Delivering a First Class Service.</a>	RCS (Eng)	2007
<b>Maternity Services</b>		
<a href="#">Guidance on staffing standards for midwifery</a>	RCM	2009
<b>Nursing standards</b>		
<a href="#">Transferring children to and from theatre</a>	RCN	2011
<a href="#">Caring for young people: Guidance for Nursing staff</a>	RCN	2012
<a href="#">RCN Paediatric Nurse Managers' Forum Children in acute independent sector hospitals</a>	RCN	2002

## Knowing what good looks like for general CYP services

The following summarises what CQC inspection teams could consider as good in terms of CYP services. It is a starter for 10 and needs to be developed further and kept under review by the National Professional Advisors recommended in **section 10**. Final judgement of whether a service is safe, effective, caring responsive and well-led will need to rest with the inspection team.

### Safe

- 2013 Royal College of Nursing guidance on nurse staffing in CYP's healthcare implemented.
- General acute paediatric rotas (at least ten WTEs, all of whom are EWTD compliant) met.
- Adhere to all CEM's Safeguarding Children's Standards.

### Effective

- All NICE Quality Standards and Clinical Guidelines relevant to CYP implemented or majority are in place with clear plans for implementation of the remainder.
- Participate in all relevant National Clinical Audits recommended by DH – in the top quartile in the majority of cases where measures exist and are validated. Some areas needing improvement but plans are in place to address these.
- Evidence of guidelines and procedures in place to recognise the sick, deteriorating or maltreated child. These are audited and there is evidence of improvement or work towards improvement and managerial support for that and escalation of care as appropriate.
- Evidence of local audit and improvement in response to local needs or concerns raised.
- Adhere to all RCPCH standards for acute paediatric services.
- Participate in specialist network(s) for relevant services provided.

### Caring

- Access to play specialists/ services 7 days a week for in-patients.
- Child-friendly format for inpatient survey.
- Access to child psychologists to support CYP with long term or complex conditions.

### Responsive

- Child specific information for all common conditions and treatment.
- Provision of age appropriate environments up to 18yrs minimum.
- Facilities for parents e.g. to stay overnight.
- Structured programme of transition to adult services.
- Training for staff in A&E on caring for CYP including those with complex needs.
- Discharge planning meetings in place for CYP with complex needs prior to discharge.
- Positive parents feedback e.g. feel their child is being safely cared for, feel well prepared and supported for their child's discharge, they would recommend the CYP service etc.
- Documentation demonstrates that CYP are listened to and their care is planned and provided to them in partnership.
- Play specialists are used to help involve CYP in decision-making and to understand their illness and treatment when appropriate.
- Communication aids and interpreters are used to enable CYP and their parents to be involved in decision-making.

### Well-led

- Trust data (quantitative and qualitative) broken down by age and considered at board level.
- Voice of parents and children is part of the governance structure e.g. a young person on the Board of Governors.

## Examples of what we would expect to see in an outstanding CYP service

### Safe

- Access to specialist medical advice available 24/7.
- One point of contact to liaise between parents of CYP and doctors from different specialities.
- 24 hour access to paediatric pharmacist.
- Joint operational policy with transport service with explicit guidelines for required clinical escort and monitoring based on acuity with audit and regular joint case review.

### Effective

- All NICE Quality Standards and Clinical Guidelines relevant to CYP implemented.
- Participate in all relevant National Clinical Audits recommended by DH and evidence of excellence in all aspects i.e. top 10% where measures exist and are validated. Any areas that need improvement have plans in place to address these.
- Demonstration of effective care by benchmarking against peers (including international comparisons). [*tertiary providers*]
- Evidence of implementation of guidelines and procedures to recognise the sick, deteriorating or maltreated child with audit of these and evidence of improvement as a result.
- Excellent shared care arrangements e.g. outreach medical and nursing services (including continuity of care for the patient), shared education, training, policies and audits.
- Evidence of excellent outcomes (top 10%) as new outcome measures come on line.

### Caring

- Qualified play specialists available for all areas a child could be seen or treated (e.g. wards, outpatient clinics, A+E, radiology etc.) seven days a week.

### Responsive

- Provision of age banded clinics to support young people up to at least 25.
- Clinicians in local hospitals /community nurses have access to specialist advice from Multidisciplinary Teams including specialist nursing services and advice from AHPs (dietitians, pharmacists, physios and other rehab staff) when needed.

### Well-led

- Joint Strategic Plan for Children's Services across the health economy that is implemented or a health and social care economy wide collaborative approach is taken, working with other agencies to improve outcomes for children and families, tackling health inequalities, planning and delivery of high quality co-ordinated services.
- A consistent track record of high quality, responsive practice which delivers good outcomes for children, young people, carers and care leaver.
- Shortlisting or winning national/international awards related to quality improvement programmes for CYP services.

## **Examples that would indicated that a CYP service requires improvement**

### Safe

- CYP on adult wards.
- CYP cared for by doctors and/or nurses (incl bank staff) with no paediatric qualifications / training.
- No early warning system to identify and manage the deteriorating child.
- Absence of safeguarding protocol regarding adults staying overnight on wards.

### Effective

- Do not participate in all National Clinical Audits/Confidential Enquiries recommended by DH and/or there are significant areas of improvement required and/or they are in the bottom quartile where measures exist and are validated.
- No children's only operating list.
- No pathway for alcohol / substance misuse or sexual abuse referrals.

### Responsive

- Lack of facilities for young people aged up to 18 years.
- Age-appropriate toilet facilities not available.
- Long waits in CAU ahead of admission to a ward.
- No method to address mental health needs of CYP.

### Well-led

- No NED for CYP on Board.
- Widespread significant negative views from children and families, staff and other stakeholders.

## **Examples that would indicated that a CYP service is inadequate**

### Safe

- Staff are unable to meet basic or safe care and treatment requirements as staffing not in line with RCN and RCPCH staffing requirements.
- Failures in practice are serious and systemic in nature.
- Less than 24/7 access to paediatric resuscitation equipment, and staff on resus team with paediatric training.
- Non-secure entrance to CYP-only areas.

### Effective

- Failure to deliver care to basic professional standards and guidance.
- Paediatric specific resuscitation equipment not available in all areas where CYP will be seen and treated.
- Paediatric specific surgical equipment is not available in shared theatres.
- No access to paediatric pharmacist.
- An inward looking culture with minimal levels of collaboration with other agencies in the planning or delivery of CYP services.

### Caring

- High levels of negative CYP / parent (e.g. fear of leaving children alone) and staff feedback (e.g. would not want own child treated there) that are not being addressed.

### Responsive

- Children and their families face inappropriate delays or are unable to access services due to avoidable barriers or inadequate management of the service.
- No facilities for parent(s) to stay overnight.
- Little or no effort is made to engage with, actively gather or use the views of children and families' experiences of the service.

### Well-led

- Lack of understanding and management of overarching performance issues in CYP services
- Cultural (bullying and harassment) issues widespread in CYP services.
- Low levels of staff satisfaction, high levels of stress, work overload and sickness in CYP services.
- Failure to take into account national reviews, learning, improvements or encourage staff development.

## Specialised paediatric health services

1. Specialised Paediatric Anaesthesia and Pain Management Services
2. Specialised Paediatric Cancer Services (paediatric oncology, malignant haematology and cancer surgery services)
3. Specialised Paediatric Cardiology and Cardiac Surgery Services
4. Specialised Paediatric Dentistry Services
5. Specialised Paediatric Ear, Nose and Throat Services
6. Specialised Paediatric Endocrinology and Diabetes Services
7. Specialised Paediatric Gastroenterology, Hepatology and Nutritional Support Services
8. Specialised Paediatric Gynaecology Services
9. Specialised Paediatric Haematology Services (excluding malignant haematology, bleeding disorders and haemoglobinopathies)
10. Specialised Paediatric Intensive Care Services
11. Specialised Paediatric Mental Health (Tier 4 CAMHS and Forensic) Services
12. Specialised Neonatal Care Services
13. Specialised Paediatric Neurosciences Services
14. Specialised Paediatric Ophthalmology Services
15. Specialised Paediatric Oral and Maxillofacial Surgery Services
16. Specialised Paediatric Orthopaedic Surgery Services
17. Specialised Paediatric Plastic Surgery Services
18. Specialised Paediatric and Perinatal Post Mortem Services
19. Specialised Paediatric Renal Services
20. Specialised Paediatric Respiratory Services
21. Specialised Paediatric Rheumatology Services
22. Specialised Paediatric Surgery Services
23. Specialised Paediatric Urology Services

**Note:** Specialised services are defined in law as those services with a planning population of more than one million people. This means that they would not be provided by every hospital in England. The Specialised Services National Definitions Set (SSNDS) describes these services in more detail. Specialised paediatric services are Definition No. 23.

**Specialised services which cover both adults and children (i.e. 'all ages' definitions)**

1. Specialised Services for Blood and Marrow Transplantation (all ages) [Definition No.2]
2. Specialised for Haemophilia and Other Related Bleeding Disorders (all ages) [Definition No.3]
3. The Assessment and Provision of Equipment for People with Complex Physical Disability (all ages) [Definition No.5]
4. Specialised Spinal Services (all ages) [Definition No.6]
5. Specialised Burn care Services (all ages) [Definition No.9]
6. Cystic Fibrosis Services (all ages) [Definition No.10]
7. Cleft Lip and Palate Services (all ages) [Definition No.15]
8. Specialised Clinical Immunology Services (all ages) [Definition No.16]
9. Specialised Services for Allergic Disease (all ages) [Definition No.17]
10. Specialised Services for Infectious Diseases (all ages) [Definition No.18]
11. Specialised Medical Genetic Services (all ages) [Definition No.20]
12. Specialised Mental Health Services (all ages) [Definition No.22]
13. Specialised Dermatology Services (all ages) [Definition No.24]
14. Specialised Rheumatology Services (all ages) [Definition No.26]
15. Specialised Ear Services (all ages) [Definition No.32]
16. Morbid Obesity Services (all ages) [Definition No.35]
17. Specialised Metabolic Disorders Services (all ages) [Definition No.36]
18. Specialised Haemoglobinopathies Services (all ages). [Definition No.38]

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**Mental Health Sector: Child and Adolescent Mental Health Services - Developing the new inspection approach: Key Stakeholder Workshop (18<sup>th</sup> March 2014)**

Names of delegates have been removed from the published version of this report.