Birmingham Women's and Children's NHS Foundation Trust

Inspection report

Birmingham Children's Hospital
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Date of inspection visit: 23 to 24 January 2024
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

The emergency department at Birmingham Children's Hospital provides a 24-hour, 7 day a week service to children and young people in the local area and beyond. The service is a member of a regional trauma network and a designated trauma unit for children and young people. The department can provide care for a wide range of medical conditions, minor illnesses, and injuries through to major trauma.

From March 2021 to February 2022, the emergency department saw over 62,957 children and young people. Children, young people and their parents/carers were referred by 999 calls, their GPs or attended 'self-referring' walking into the reception area. There were 5 beds and a cubicle in the observation area, 10 cubicles, 3 resuscitation beds, 19 bedded paediatric assessment unit and the clinical decision unit had 11 beds for GP, specialty referrals and for accommodating patients waiting for admission. The minor injury area consisted of a treatment room, 5 bed spaces and a seating area.

We inspected the service on the 23 and 24 January 2024. The inspection team comprised an operations manager, 2 inspectors, 3 specialist advisors which included a consultant in paediatric emergency medicine, a modern matron and a Child and Adolescent Mental Health Service specialist advisor. An operations manager oversaw the inspection.

During our inspection, we visited all areas within the children's emergency department including paediatric assessment unit.

Throughout our inspection we spoke with 34 staff including doctors, nursing staff of various grades, healthcare support workers, advanced nurse practitioners and managers.

We reviewed a total of 26 patient records and spoke with 12 children, young people and their relatives.

You can find further information about how we carry out our inspections on our website.

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

Our findings

- The service provided mandatory training in key skills but not all staff completed it. The service did not provide training to care for patients with complex needs. Not all relevant staff were trained to the appropriate level of life support training. The service did not always control infection risk well. Staff did not always use control measures to protect patients from infection. The design and use of facilities and premises did not always keep people safe. There was limited provision for specialist mental health assessment for patients presenting with acute mental health needs. Controlled drug recording did not always follow the Misuse of Drugs regulations 2001. Learning from serious incidents was not always embedded to improve patient safety.
- Not all staff knew how to protect the rights of patients subject to the Mental Health Act 1983. Not all staff understood their responsibilities in managing patients experiencing mental ill health. The service did not always monitor the effectiveness of care and treatment. Not all staff had received training in consent, Mental Capacity Act and Deprivation of Liberty safeguards.
- The service was inclusive but did not always take account of patients' individual needs and preferences. People did not always receive the right care promptly.
- The service did not always collect reliable data to enable them to analyse it to inform performance monitoring and future improvements. Information systems were not all integrated. Implementation of quality and safety improvements was not always timely. Arrangements were in place with partners and third-party providers, but these were not always effective.

However:

- Staff-maintained equipment well and were trained to use it. Staff quickly acted on patients at risk of deterioration. Managers regularly reviewed staffing levels and skill mix, and gave bank staff a full induction. Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. The service managed patient safety incidents well.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff gave patients enough food and drink to meet their needs. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. The service made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. Key services were available 7 days a week to support timely patient care. Staff gave patients practical support and advice to lead healthier lives.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned and provided care in a way that met the needs of local people. People could generally access the service when they needed it. It was easy for people to give feedback and raise concerns about care received.
- Leaders had the skills and abilities to run the service. They were visible and approachable. The service had a vision for what it wanted to achieve and a strategy to turn it into action. Staff felt respected, supported and valued. Leaders and staff actively and openly engaged with patients, staff and equality groups. They collaborated with partner organisations to help improve services for patients.

Areas for improvement

MUSTS

Urgent and Emergency Care

Our findings

- The trust must ensure controlled drug records are accurately documented as set out in the Misuse of Drugs regulations 2001 and amendments and there are suitable and safe storage arrangements available for all medicines. Regulation 12(1)(2)(e)(g): Safe care and treatment.
- The trust must ensure patients have timely access to mental health services. Regulation 12(1)(2)(a)(b): Safe care and treatment.
- The trust must ensure there is a suitable mental health room including toilet facilities which complies with statutory requirement. Regulation 15 (1)(c): Premises and equipment.
- The trust must have systems and processes in place to enable staff carry out regular audits, such as sepsis audits in order to monitor and improve patient safety. Regulation 17(1): Good governance.
- The trust must ensure all staff complete mandatory training, including but not limited to safeguarding, learning disability and Mental Capacity Act training. Regulation 18 (2)(a): Staffing.
- The trust must ensure all relevant medical and nursing staff are trained to the required level of life support for the care and treatment they are delivering. This includes ensuring there is always a nurse in charge with this training on duty in line with the Royal College of Nursing safe staffing guidelines. Regulation 18 (1)(2)(c): Staffing.
- The trust must ensure staff are provided with training in the Mental Health Act and staff understand the code of practice. Regulation 18(1)(a): Staffing.
- The trust must ensure staff receive relevant training for restrictive intervention, such as management of actual and potential aggression as per National Institute for Health and Care Excellence guidance. Regulation 18(1)(a): Staffing.

SHOULDS

Urgent and Emergency Care

- The trust should ensure staff follow infection, prevention and control processes. This includes but is not limited to consistently embedding trust hygiene and cleanliness standards and ensuring standards for managing peripheral venous and central venous catheters are met to reduce the risk of infection. Regulation 12.
- The trust should ensure there is always appropriate sight and supervision of patients in the emergency department and waiting areas. Regulation 12.
- The trust should ensure staff fully implement trust policies and procedures when undertaking enhanced supervision of patients at risk of self-harm. Regulation 12.
- The trust should ensure all guidance in relation to medicines management that is available to staff is always up to date to ensure national guidance is followed. Regulation 12.
- The trust should ensure safety checks of emergency equipment including but not limited to defibrillators are checked to ensure they are working and safe to use in line with trust policy. Regulation 15.
- The trust should ensure wheelchairs are available for patients to use if required. Regulation 15.
- The trust should ensure intravenous guidance in resus area is up to date. Regulation 17.
- The trust should consider effective pathways are fully embedded between the Child and Adolescent Mental Health Service (CAMHS) and the emergency department. Where the CAMHS team do not respond within agreed timescales, the service should ensure staff are escalating these concerns so that patients receive care and treatment in a timely manner. Regulation 17.

Our findings

- The trust should ensure that records are accessible to both emergency department staff and the mental health team. Regulation 17.
- The trust should ensure there are enough suitably qualified staff across all clinical areas, to make sure the service can meet people's care and treatment needs. This includes medical, registered nursing and non-registered nursing staff. Regulation 18.
- The trust should consider having play areas for children with complex needs.
- The trust should consider implementing a process to monitor the use of sedation or rapid tranquilisation, to be assured that administration is in line with policy, not excessive and appropriate.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡑	🡑🡑	🡓	🡓🡓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔🡐 Jun 2024	Good ➔🡐 Jun 2024	Good ➔🡐 Jun 2024	Requires Improvement ➔🡐 Jun 2024	Requires Improvement ➔🡐 Jun 2024	Requires Improvement ➔🡐 Jun 2024

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Birmingham Children's Hospital	Requires Improvement ↓ Jun 2024	Good ↓ Jun 2024	Outstanding →← Jun 2024	Good ↓ Jun 2024	Requires Improvement ↓ Jun 2024	Good ↓ Jun 2024
Birmingham Women's Hospital	Good Jun 2023	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Jun 2023	Good Jun 2023
Overall trust	Requires Improvement →← Jun 2024	Good →← Jun 2024	Good →← Jun 2024	Requires Improvement →← Jun 2024	Requires Improvement →← Jun 2024	Requires Improvement →← Jun 2024

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Birmingham Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Outstanding Mar 2023	Outstanding Mar 2023	Good Mar 2023	Good Mar 2023	Outstanding Mar 2023	Outstanding Mar 2023
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017
Medical care	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	Not rated	Outstanding Feb 2017	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017
Surgery	Requires improvement Mar 2023	Good Mar 2023	Good Mar 2023	Good Mar 2023	Good Mar 2023	Good Mar 2023
Transition services	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Urgent and emergency services	Requires Improvement ↓ Jun 2024	Requires Improvement ↓ Jun 2024	Good →← Jun 2024	Requires Improvement ↓ Jun 2024	Requires Improvement ↓ Jun 2024	Requires Improvement ↓ Jun 2024
Overall	Requires Improvement ↓ Jun 2024	Good ↓ Jun 2024	Outstanding →← Jun 2024	Good ↓ Jun 2024	Requires Improvement ↓ Jun 2024	Good ↓ Jun 2024

Rating for Birmingham Women's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement Nov 2019	Not rated	Requires improvement Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Requires improvement Nov 2019
Gynaecology	Requires improvement Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Maternity (community services)	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Neonatal services	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Maternity	Good Jun 2023	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Jun 2023	Good Jun 2023
Overall	Good Jun 2023	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Jun 2023	Good Jun 2023

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health crisis services and health-based places of safety	Requires improvement Mar 2023	Good Mar 2023	Requires improvement Mar 2023	Good Mar 2023	Requires improvement Mar 2023	Requires improvement Mar 2023
Specialist community mental health services for children and young people	Requires improvement Dec 2023	Requires improvement Dec 2023	Requires improvement Dec 2023	Requires improvement Dec 2023	Requires improvement Dec 2023	Requires improvement Dec 2023
Child and adolescent mental health wards	Requires improvement Mar 2023	Good Mar 2023	Good Mar 2023	Good Mar 2023	Requires improvement Mar 2023	Requires improvement Mar 2023

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

Birmingham Children's Hospital

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Description of this hospital

Birmingham Women's and Children's NHS Foundation Trust is responsible for managing Birmingham Women's Hospital, Birmingham Children's Hospital and Forward-Thinking Birmingham. It was created by a merger of Birmingham Women's NHS Foundation Trust with Birmingham Children's Hospital NHS Foundation Trust in February 2017. The trust is 1 of 5 trusts within the Birmingham and Solihull Integrated Care System. It has an annual turnover of £535 million, and provides a range of general and specialised services, including tier 4 children's and young persons mental health services to young people up to the age of 25 years.

We carried out this unannounced inspection of the urgent and emergency care core service at Birmingham Childrens Hospital on 23 and 24 January 2024 because we received information giving us concerns about the safety and quality of the services. We did not look at any other services.

Our overall rating of the location went down. We rated them as requires improvement.

Urgent and emergency services

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills but not all staff completed it. The service did not provide training to care for patients with complex needs. Not all relevant staff were trained to the appropriate of life support training.

Nursing staff received and generally kept up to date with their mandatory training. Following our inspection, the service provided us with a breakdown of mandatory training compliance data at the time of our inspection. Registered Nurses (RN) were compliant with the 95% mandatory training target in 9 out of 12 modules. All non-registered staff had completed their mandatory training.

Medical staff received but were not up to date with their mandatory training. Data provided to us following our inspection showed medical staff were not compliant with any of the 12 mandatory training modules.

Mandatory training was comprehensive and met the needs of patients and staff. Training modules included key areas, such as: risk, health and safety, fire safety, manual handling, infection prevention and control, conflict resolution, information governance and basic life support. Training was a combination of face to face and online learning.

Compliance to the highest level of life support training was not achieved for medical or nursing staff. Data provided to us following our inspection showed only 19 out of 24 medical staff (79%) had completed Advanced Paediatric Life Support (APLS) or equivalent. Data also showed RNs undertaking nurse in charge duties had not all completed APLS training. For example, 15 out of 17 (88%) band 7 or 8 RNs, and only 6 out of 17 (40%) of band 6 RNs who took on the nurse in charge role had completed it. Data provided to us following the inspection showed 75% of relevant nursing staff and had completed paediatric immediate life support training. Managers told us there was a plan to improve compliance. Senior staff always ensured an APLS trained nurse was on duty on each shift to maintain safety. All staff required to complete this training were booked on. Managers told us the on-call emergency team were all trained to the highest level of life support which provided some mitigation.

Clinical staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities and autism. At the time of our inspection, the service had not fully implemented mandatory learning disability and autism training in line with national guidance. None of the RNs or medical staff had completed this training at the time of our inspection. However, 33% of non-registered staff had completed this. The trust had a dedicated learning disabilities liaison nurse who provided support to staff. Managers told us there was an action plan in place to ensure all staff had completed it.

Mental health training was not mandatory. Following our inspection, the service did not provide us with data to demonstrate who had completed mental health training. Some staff had received de-escalation training, and this was being rolled out to the rest of the team. Staff were not trained in restrictive interventions but were required to restrain patients when delivering rapid tranquilisation.

This meant patients with complex needs were not always care for and treated by staff who had received relevant training to meet their personalised needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us managers prompted them to complete mandatory training when required. Managers received notification alerts when staff training was almost out of date. The emergency department had education leads to facilitate and maintain access to training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse.

Nursing staff received training specific for their role on how to recognise and report abuse. Data provided to us following our inspection showed the 95% compliance target was exceeded for safeguarding adults and children level 2 and safeguarding children level 3 training for RNs. Furthermore, most (91%) non-registered nursing staff had completed level 2 safeguarding adults children training.

Medical staff received training specific to their role on how to recognise and report abuse, however, compliance was low and did not meet the 95% trust compliance target. Data provided showed 52% of medical staff had completed safeguarding adult and children level 2, and 49% had completed level 3 training. This was not in line with national guidance which states all staff assessing and treating children should be trained to level 3. Following our inspection, data provided by the trust showed improved figures. Data showed, 88.9% senior of medical staff were up to date on safeguarding level 2 training and 77.8% were up to date on safeguarding level 3 training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff professional standards of practice and behaviour were underpinned by values of equality and diversity. This meant staff treated children and young people as individuals, avoided making assumptions about them, recognised diversity, individual choice, and respected and upheld their dignity and human rights.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff provided examples of how they identified children at risk. We saw examples where staff had worked with other agencies to safeguard a child and ensure a safe discharge.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff provided us with examples of where they had previously made safeguarding referrals for both children and adults. From July to December 2023, the urgent care department made 243 safeguarding referrals. The service audited the quality of safeguarding referrals. They categorised them as either poor, adequate, good, or outstanding. In July 2023, the audit showed 100% of referrals were 'adequate'. As a result, a 7-minute briefing note for staff was implemented to explain how to complete a good safeguarding referral. Following this, audits showed improvements had been made. In August 2023, 20% were rated as 'outstanding', 40% as 'good' and 40% as 'adequate'. In October 2023, 50% were rated 'good' and 50% as 'adequate'.

Urgent and emergency services

Staff followed safe procedures for children visiting the department. Frequent attenders were highlighted on the system. Safeguarding alerts were positioned in the first page of the child's medical records. Child protection documents were also present at the front of a file. Triage staff escalated children who needed mental health support by giving them a red card, so clinicians knew they needed to prioritise them. Children who were at high risk had an alert next to their name on the electronic white board, so staff were aware there was a risk. Staff completed safety netting on the care records we reviewed, and an electronic alert system was in place to enable staff flag up any child protection concerns. A safeguarding team was in place and provided families with early help and social support.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. Furniture such as beds, chairs, and mattresses were in good condition to allow for effective cleaning. Staff used washable curtains and maintained a record of when they were last changed.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Domestic and housekeeping staff were present across the department on the days of our inspection. This meant staff could request timely deep cleans and decontamination.

The service did not always perform well for cleanliness. The service undertook quarterly infection, prevention, and control audits. The audits completed from October to December 2023 showed an average 87% compliance with audit standards. However, 8 areas were assessed as 'inadequate' and not meeting the service compliance standards. We saw a list of actions to improve but there was no evidence of action being taken. During our inspection, the service was undergoing major building works and dust was a recognised issue. We were told action was taken immediately when issues such as dust were identified. The clinical team, estates and facilities teams held weekly meetings and discussed cleanliness and infection prevention and control.

Peripheral Venous Catheter (PVC) insertion audits completed from October to December 2023, showed 100% compliance with audit standards in October and November, but compliance levels fell below expected standards to 72% in December 2023. Furthermore, compliance with PVC access audits was consistently below trust compliance levels with an average compliance of 80% from October to December 2023. This meant there was a risk of a patient developing a site infection. Central Venous Catheter access audits completed over the same period showed an average 93% compliance with audit standards. Further data provided by the trust showed an improvement in April with insertion figures at 98.5%, access figures at 94.8% and ongoing care figures at 96.2%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were observed wearing appropriate PPE and sanitising their hands. Following our inspection, the service provided us with the outcomes of hand hygiene audits from October to December 2023 which showed an average 97% compliance with standards set. Patients with infections or at risk of harm from infection were clearly identified and cared for in cubicles and side-rooms.

There were robust systems and processes in place to manage the increased prevalence of measles in the area. We observed staff carrying out measles streaming at the emergency department main entrance. They wore enhanced PPE, such as face masks and visors. This was covered on a rotational basis by clinical support workers. Immunocompromised patients at risk of contracting measles were quickly identified and segregated from patients with suspected measles.

Urgent and emergency services

Information was visible in the reception area to tell the public about an increase in measles cases locally. Staff asked vulnerable patients to be mindful, stay safe and isolate anyone with and rash fever straight away.

Staff used an early help assessment room as a laboratory to process test results, such as rapid testing for COVID-19 and seasonal flu. All patients requiring admission received a rapid test.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to identify when an item of equipment had been cleaned and was ready for use.

Environment and equipment

The design and use of facilities and premises did not always keep people safe. Checks of emergency equipment were sometimes missed. Staff-maintained equipment well and were trained to use them. They managed clinical waste well.

The design of the environment did not always follow national guidance. Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. There was no mental health assessment room. Staff commonly used a specific cubicle to assess a patient's mental health, but it was not fit for purpose. There were 2 exits which did not meet the required standards set out in the Quality Standards for Liaison Psychiatry Services. There were fixed ligature points, doors did not open out both ways, there was no sturdy seating and no strip alarm. However, when used staff told us they could remove most of the equipment in the room if needed. Staff recorded incidents where the lack of a suitable 'safe space' had resulted in closing areas of the emergency department. There was only 1 toilet to serve the whole of majors and minors. It had several ligature points. Following our inspection, 2 mental health educators and psychiatric liaison nurses joined the team. They were in the process of undertaking ligature risk assessments across the department. The service had also trained 100 staff in the department in ligature risk awareness and use of ligature cutters.

Staff told us they intended to refurbish a cubicle which would be designated for patients with acute mental health concerns. Charity funding had been secured to refurbish cubicle 3 but work had not yet started. A new built elective care hub was under development with plans to expand the emergency care department to the ground floor. Following our inspection, we were told a task and finish group had been established to oversee the work required to bring the cubicle and bathroom in line with relevant standards. Furthermore, since our inspection, the trust had been awarded £5m to reflect its good operational performance in the emergency department as part of the winter incentive scheme. This will be fully invested into improving the department.

The layout of the department meant staff did not always have sight of all patients waiting in the department. There was poor line of sight in the waiting area and in both the majors and minors area. A cubicle used to isolate patients was not observable to staff unless they went into the room. Staff told us there were usually 2 staff overseeing this area to maintain supervision of patients. However, during our inspection, we saw on 2 occasions for short periods of no longer than 2 minutes no staff were present in the area. Staff told us they would escalate to the nurse in charge where they were unable to have full sight of patients. In further evidence provided, the trust told us mitigations such as an increased number of staff allocated to triage, hourly rounding in the waiting area during busy periods and an increased number of volunteers in the waiting area were used to reduce risk.

There was a dedicated space for patients who were assessed as safe to wait. For example, patients waiting for take home medicines or to be seen by a clinician.

Urgent and emergency services

Patients could reach call bells and staff mostly responded quickly when called. Parents we spoke to told us staff responded to call bells within reasonable timescales.

Staff did not always carry out daily safety checks of specialist equipment. We could not be assured emergency equipment always received required checks. Daily defibrillator checks in the main department were inconsistent with 4 daily checks missed in November 2023, 8 in December and 4 in January 2024. Defibrillators were, however, all subject to automatic checking which sent remote diagnostic reports to the medical engineering team. We found there were checks of anaesthetic machines, airway trolleys, central line and chest drain kits. We checked the resuscitation trolley in the observation area and found equipment checks had been completed and all items for use in an emergency were in date.

Equipment was not always readily available to support patients to mobilise. For example, we observed a child being discharged with a crutch from an annexe area following a road traffic collision and there was lack of wheelchairs in place. We raised this with staff who said getting hold of wheelchairs was always challenging. Due to the location of the department, patients had to walk a distance where wheelchairs were not available. Following our inspection, the trust placed an order for additional wheelchairs.

Staff did not always have necessary equipment to keep them safe. Not all staff wore personal alarms. Reception staff said they had a panic button under the desk but could not locate it. Security guards were supposed to be in position 24 hours a day but there were times they were not present on day one of our inspection. Security could however, be reached via a short dial call in an emergency and more security guards were situated in the main hospital if required. Following our inspection, the trust told us emergency call bells were available in all rooms and they were in the process of rolling out de-escalation training as a method of safeguarding staff.

The decontamination unit had been moved outside of the building due to ongoing construction work. Only authorised people had access to the unit.

The general waiting area had wipeable chairs, digital screens, and a speaker system in place in various languages. There were 2 isolation rooms where patients with suspected communicable disease could be isolated.

A domestic cupboard was available and had warning signs in place to indicate cleaning chemicals were being stored in the room. Staff gained access using a swipe cards.

Diagnostic services were generally close to the emergency department to support timely access. The imaging department was located next to the emergency department and the computer topography department was located approximately 10 minutes away from the department. A rapid response was always available for trauma patients.

Staff disposed of clinical waste safely. Needle sharps bins were available throughout the emergency department and the bins we inspected were labelled and stored correctly.

The service undertook regular environmental audits. Following our inspection, the service provided us with the outcomes of their last quarterly environmental audit completed in November 2023. This showed 87% compliance with audit standards set.

Assessing and responding to patient risk

Most patients received a triage within 15 minutes and systems were in place to prioritise the sickest patients. Staff quickly acted on patients at risk of deterioration. There was limited provision for specialist mental health

assessment for patients presenting with acute mental health needs. Staff did not understand their responsibilities to manage patients who were held under the Mental Health Act. Staff did not always ensure patients requiring enhanced supervision due to risk of self-harm received this in line with their risk management plan.

There were processes to stream, triage and assess patients attending the department. Triage was open 24 hours a day and was staffed by a registered children's nurse. A standard operating procedure was available for triage, and this was displayed on the wall within the triage room. Staff completed a triage risk assessment for each patient on arrival, using a recognised tool.

In general patients received a triage within 15 minutes of arrival at the department. This was in line with national guidance by the Royal College of Emergency Medicine. A system of prioritisation for assessment was in place where the triage waiting time exceeded 15 minutes. This ensured the sickest patients were prioritised and escalated. We reviewed 11 patient records at the point of triage, and all had undergone a triage and first set of observations within 15 minutes of arrival. The average time to triage and first set of observations during the 2 days of our inspection was 16 minutes. Data provided by the trust during factual accuracy showed 44.7% of patients attending on these days were seen within the 15-minute. The service was recruiting additional triage nurses following a successful business case.

Data showed since May 2023, the percentage of patients attending with higher acuity had significantly increased. In December 2023, 15% of patients attending were urgent which had increased from 11% in November 2023. However, overtime, the trust's median time from arrival to initial assessment were consistently shorter (better) than the national average from October 2021 to September 2023. The figures for the trust ranged between 2 and 4 minutes over this time, compared with the England average which ranged between 8 and 11 minutes.

Patients were not always seen by doctors within an hour during peak times. However, staff prioritised patients according to the seriousness of their condition at the point of triage.

Triage nurses colour coded children depending on the outcome of their triage. This helped staff to prioritise patients based on their clinical presentation and other social factors and mental health status. Patients who presented with symptoms, such as bleeding, overdose, suspected sepsis, trauma, or sickle cell were flagged up as orange and received an immediate review from a doctor.

Triage staff escalated children who needed mental health support by giving them a red card, so clinicians knew they needed to prioritise them. Children who were at high risk had an alert next to their name on the electronic white board, so staff were aware there was a risk. Frequent attenders were highlighted on the system.

There were processes for receiving pre-alerts from local ambulance services for patients they were conveying in an emergency. The nurse in charge reviewed and registered patients on arrival and a team of staff were ready for the patient on arrival. Staff understood their roles and responsibilities.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the Paediatric Early Warning Score (PEWS) system to assist them with the early recognition of sick patients and management of any deterioration. We found where PEWS showed signs of deterioration, they were immediately escalated, and patients received an immediate senior clinician review. Monthly audits from July to December 2023, showed an average 96% compliance with patient observation recording, frequency, and escalation standards.

Urgent and emergency services

Staff completed assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. In 8 patient records who had been assessed by a doctor, we found a good standard of documentation with key elements, such as past medical history, medication history and allergies clearly documented.

Staff knew about and dealt with any specific risk issues. There were systems in place for the identification and management of sepsis. Sepsis tools and pathways were in place and records we reviewed reflected appropriate management. Staff we spoke to had good knowledge of sepsis, processes for screening and escalating for priority medical review.

Four patient records we reviewed had been categorised at the point of triage as 'orange' triage category due to them being assessed as high risk of sepsis. We saw they all underwent a sepsis screen and were quickly escalated for a consultant review. We saw evidence antibiotics were prescribed and administered in a timely manner where a patient was assessed as at risk of sepsis.

Compliance with sepsis screening and treatment was not routinely audited. This meant there were missed opportunities to identify non-compliance and share learning with staff to improve practice and safeguard patients from ongoing risk of harm.

The service had Local Safety Standards for Invasive Procedures (LocSSIPs) to support staff in undertaking invasive procedures in the department. For example, we saw there was a LocSSIP in place for undertaking wire-guided lines and pleural drain insertion in the emergency department.

Staff checked all blood results including radiology results daily and provided feedback to patients. We were shown an example where an abnormal blood result was identified through the checks and appropriately managed.

Staff did not always know about specific risk issues in relation to mental health. Staff had not received training to manage patients presenting with mental health crisis. Staff were not clear about their responsibilities to hold a child in the emergency department who was not safe to leave the building. Staff said they would call the police if such a child attempted to leave but did not mention a clinician's ability to detain a patient under Section 5 (2) and Section 5 (4) of the Mental Health Act. This finding indicated staff had not learned lessons from a major incident in 2022 when a child attended under S17 leave and absconded from the department.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff completed a mental health document to assess a patient at risk of self-harm or suicide. This indicated what specific support the patient required so staff could contact the most relevant mental health team.

There were gaps in enhanced supervision for patients requiring it. A patient had been placed on level 2 observation (every 15 minutes) due to risk of self-harm. We saw gaps in the recording from 7.15 to 8.45am, and 8.15 to 9.45pm on the 22 January 2024. The patient was allowed to use the toilet unobserved with locked doors.

The service did not have 24-hour access to mental health liaison and specialist mental health support. Dedicated mental health support and expertise was available through the urgent care service at Forward Thinking Birmingham, which was part of the trust. Staffing vacancies in the psychiatric liaison team and Child and Adolescent Mental Health Service (CAMHS) team impacted on their ability to provide a responsive service to the emergency department.

The psychiatric liaison service was not in operation due to vacancies. CAMHS ran from 8am to 8pm. Out of hours cover was operated by a shift co-ordinator. CAMHS were not based on site at the children's hospital. Staff had to add

approximately half an hour travel and parking time to their response time before arriving at the emergency department. However, there was a psychiatrist on call 24 hours a day, 7 days a week. Additional evidence from the trust showed psychiatric liaison nurses had joined the team and provided on-site support from 8 am to 4 pm. The trust also held hospital control centre meetings 3 times a day. Staffing was adjusted to meet demand across the hospital and staff could request additional supervision if required.

We reviewed the time it took for children who were assessed as needing to be seen by a CAMHS professional from the beginning of January 2024. Out of 19 children who presented with a mental health disorder, 7 were assessed as needing to be seen by a CAMHS professional. Although seen by an emergency department clinician quickly (quickest was 9 minutes, longest was 40 minutes), the time to be seen by a CAMHS professional ranged from 292 minutes to 1,208 minutes. The 4-hour target was rarely met. Staff did not escalate this breach to senior staff.

Staff said they did not get a timely response from CAMHS. The CAMHS team allocated to the children's hospital were also responsible for serving 4 other acute hospitals and the community across the whole of Birmingham.

Working arrangements between the CAMHS team and the emergency department staff had improved but were not yet embedded. There was not a smooth pathway for children and young people with mental health needs coming through the emergency department.

Staff shared key information to keep patients safe when handing over their care to others. However, CAMHS practitioners were not routinely sent discharge plans.

Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Nurse staffing levels was included on the service risk register. 'Red' flag shifts were recorded when there was a shortfall in staffing of more than 8 hours or 35% of RN time available, and where patient care was or could be impacted. This impacted the service's ability to manage increases in demand and higher acuity patients, as well as ensure suitable skill mix to effectively manage flow through the department. From October to December 2023, the service reported there were 16 red flag shifts.

Staff shortages impacted on staff ability to administer medicines, triage patients in a timely manner, complete patient observations and meet patients personalised needs. On some shifts there were a high proportion of newly qualified nurses which meant there was more pressure on qualified nurses to take on additional tasks, such as supervising and checking medicines where staff had not completed medicines competencies.

There were not always enough nurses on triage to manage the number of patients attending which impacted the time to triage. Previously the service had a second nurse available for triage, but this post was removed to support the development of the clinical decision unit. The service hadsecured funding to increase the triage nurse capacity and plans were in place to recruit. The service had rolled out a programme of triage training and 46 out of 81 nurses had received training.

Urgent and emergency services

The service had high vacancy rates. The service had agreed to increase the nursing establishment following a successful business case and this had an impact on the vacancy rates.

Data showed in December 2023 there were 4.9 whole time equivalent (WTE) band 5 RN vacancies which equalled a 14% vacancy rate. However, for band 6 nurses the service was just over establishment. There was a high vacancy rate for healthcare support workers with 6.9 WTE positions vacant. The service had a recruitment plan in place and a business case had been approved to increase the establishment. Managers told us they had planned start dates for staff recruited and expected to be at full establishment by April 2024.

The psychiatric liaison team was not in operation due to vacancies. The psychiatric liaison post had recently been filled, awaiting recruitment checks. This post would be on site at the emergency department from 9am to 5pm. There were no plans for out of hours psychiatric liaison cover.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Current staffing requirements were calculated using a recognised staffing tool. The Royal College of Emergency Medicine baseline emergency staffing tool was used alongside an adapted tool supported by NHS England.

The service met the Royal College of Paediatrics and Child Health (RCPCH) standard of having 2 RNCs on each shift. Data showed from July to December 2023, all shifts had a minimum of 2 RCNs. Furthermore, data showed the service had a minimum of 1 staff member trained in advanced paediatric life support on shift which was in line with RCPCH standards.

The department manager could adjust staffing levels daily according to the needs of patients. Managers told us they reviewed staffing levels daily, used bank staff and moved staff around to mitigate risk. When staffing was not meeting planned levels, the trust would use bank staff. All bank staff we spoke with had completed an induction and were familiar with the department.

There were Hospital Operations Centre meetings 3 times a day where staffing levels and activity were reviewed. At these meetings agreements were made to move staff to the emergency department to balance risk and safety. Managers used other teams to support the department at times of peak demand.

We observed a nursing handover from the night to day team. It was organised and covered relevant information including staffing levels and departmental pressures. Staff were allocated based on skill mix. There was a nurse in charge on each shift supported by RNs and healthcare support workers. Shift start times were staggered to support busier times.

On occasions, the number of nurses and healthcare assistants did not always match the planned numbers. When the service was unable to fill shifts with substantive staff, temporary staffing was used. From January to December 2023, between 3% and 3.7% of shifts were not filled. An electronic system was in place to plan the rota and ensure the correct use of skill mix.

The service had high turnover rates. From January to December 2023, the average turnover for RNs was 15.6%. The turnover reached a peak in July 2023 of 19.2%, this had reduced to 12.6% by December 2023. For healthcare support workers, the average over the same time was 11.5% which had increased over this time and was at 14.8% in December 2023.

Urgent and emergency services

The service had higher sickness rates than the target of 4%. From January to December 2023, the average sickness rate for RNs was 5%. Furthermore, the average sickness rate for non-registered nursing staff over the same time was higher at 7.8%. Stress was the most common reasons recorded for sickness.

Managers relied on temporary staffing and had high levels of temporary staffing. The service did not used an external agency. They covered unfilled shifts that could not be filled with substantive staff, using the trust internal temporary staffing team. They relied on this to cover shifts due to vacancies and sickness. The risk register stated there was a reliance on bank staff. However, they made sure all temporary staff had a full induction and understood the service.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. There were 9 consultants who provided onsite cover from 8am to midnight in the department. A consultant was on call overnight with an expectation to attend site when required. During our inspection, we observed there was a visible presence of consultants in the department who were coordinating referrals and supervising junior doctors.

The medical staff did not always match the planned number. Data showed from 27 November 2023 to 21 January 2024, 3 consultant shifts were unfilled and 13 middle grade doctor shifts were unfilled. Managers told us they rarely had unfilled consultant shifts as these were filled with locums where required.

The service had high but reducing turnover rates for medical staff. Data showed from January to December 2023, the average turnover was 10.3%. However, the turnover had reduced from October (10.9%) to December 2023 (6.1%).

Sickness rates for medical staff were low. From January to December 2023, the sickness rate was 1.2%.

The service had high and increasing vacancy rates for medical staff. There were no vacancies for consultants but a number of vacancies for junior doctor posts of varying levels of experience. The service had high rates of bank and locum staff to cover shifts. Managers could access locums when they needed additional medical staff. Locum support was booked in peak times, such as winter pressures and during training.

Managers made sure locums had a full induction to the service before they started work. Processes were in place to ensure locums had an understanding of the trust's systems to make sure they could deliver safe, effective and efficient care to patients.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. An electronic rota system was in place for medical staff to put in their shift request which helped increase staff flexibility.

The service always had a consultant on call during evenings and weekends. Junior doctors and nurses confirmed they could always contact a consultant for advice or support.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were a combination of electronic and paper records. Tools and templates were available for staff to use to aid their assessment of patients. We found they were fully completed in most records we reviewed.

When patients transferred to a new team, there were sometimes delays in staff accessing their records. Patients admitted had access to electronic and paper records. However, staff working in the acute hospital could not access the mental health team's shared electronic database. This meant they could not search for previous mental health history. Contact details for social workers were available for staff to review in care records. Assessments by the CAMHS team were handwritten in the patient's notes.

Records were stored securely. We saw all computers locked which required individual swipe cards or passwords to access.

Medicines

Staff did not always store or manage medicines safely or securely. Controlled drug recording did not always follow the Misuse of Drugs regulations 2001 and amendments. The service used systems and processes to safely prescribe and administer medicines.

Medicines information was available to staff; however, it was not always up to date to ensure national guidance was followed. For example, the service had recently updated its pain relief guidance to ensure the doses of medicines prescribed for acute pain were accurate and in line with current national prescribing guidance. Education of staff on the new guidelines was in progress. However, we found some intravenous (IV) drug guidelines in the resuscitation area were out of date. These guidelines were also available on the trust intranet but in date. This posed potential risk of having expired IV guidelines in resus and patients receiving medicine. We raised this as an issue with senior staff who immediately replaced them.

Information on missed doses of medicines was not currently available for the emergency department which was not possible to undertake with the current systems and processes. However, the implementation of a trust wide electronic prescribing and administration system was to be introduced.

Staff did not always store or manage medicines safely or securely. Medicines storage areas seen were locked and secure with access only to authorised staff. However, medicines were not always managed and stored safely. This was mainly due to the lack of suitable storage arrangements for some medicines. We observed some drawers used for medicine storage were overfilled. This meant medicine containers became damaged by the drawer above, and therefore some medicine identification information was missing. This increased the potential risk of a medicine error. Following our inspection, staff said although one of the drawers was overfilled, this was because one of the other cupboards had been damaged, and we were told it has now been repaired. This was therefore a short-term measure.

Controlled drugs (CDs) are medicines requiring more control due to their potential for abuse) were stored safely and securely with access restricted to authorised staff. Checks were undertaken and recorded by 2 staff twice a day which showed they were within date and stock balances were accurate. However, we found 3 errors in CD recording which did not follow the Misuse of Drugs regulations 2001 and amendments. Evidence provided following our inspection showed the pharmacy department undertook audits of CD recording and compliance was 94.4% for February and 96.6% in April 2024.

The service told us they ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. A guidance for the management of children with behavioural, mental health or social complexities was in

place for patients attending the emergency department. The guidance had been recently reviewed. The guidance was focused on using the least restrictive methods to manage a patient’s behaviour. There was a medical management process in place with a sedation assessment prior to administration of any medicines. However, managers did not monitor the use of sedation or rapid tranquilisation. They told us medicines were rarely used to manage patients’ behaviour. The service was unable to provide us with records to determine whether incidents of sedation use, or administration of rapid tranquilisation was in line with policy, excessive or appropriate. Following our inspection, the service put in place arrangements to record any administration of rapid tranquilisation.

Staff followed systems and processes when safely prescribing and administering medicines safely. Staff knew how to contact pharmacy for advice and processes were in place for the supply of medicines. At the time of our inspection, there was no clinical pharmacy service within the emergency department. However, a feasibility review of the service was being undertaken for consideration.

Medicine administration was recorded with the required information necessary, such as a medicine history, to ensure the safe prescribing and administration of medicines. Audits completed monthly from July to December 2023, showed an average of 94% compliance with medicines administration standards.

Patient Group Directions (PGD) had recently been updated which staff could easily access. PGDs allow specified health professionals, such as nurses to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. They were written in line with national guidance including the British Childrens National Formulary and supported nurses to administer medicines safely. Nurses had undergone medicines management training.

Staff reviewed each patient’s medicines regularly and provided advice to patients and carers about their medicines.

Medicines records seen were accurate and up to date. Documentation of medicines administration including routes of administration and specific times of administration were completed on all the medicine records reviewed.

Allergy statuses of patients were recorded on all medicine charts seen. This meant any known allergies were highlighted which is important when prescribing medicines. The weights and age of children were recorded on all medicine charts seen. This is important information to ensure the right dose of medicine is prescribed based on the body weight of a child.

Resuscitation medicines required in an emergency followed Resuscitation Council (UK) guidance. Staff recorded safety checks daily on emergency medicines and equipment to ensure they were safe to use.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from medicine safety alerts and incidents to improve practice. The trust had an electronic system for recording medicine incidents and staff we spoke to were able to identify its use and how to access the system. Staff knew how to report any medicine incidents and lessons learnt were shared with staff including any updates and training required.

Medicine safety posters were in place throughout the department with reminders about standards for safe medicine administration, ensuring the right medicine is given to the right person, at the right time, at the right dose and the right route.

The trust had a Medicines Safety Officer (MSO) in line with NHS England directives. The MSO investigated concerns of safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, learning from serious incidents was not always fully embedded to improve patient safety. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns and reported incidents and near misses in line with trust policy. Staff we spoke to understood what constituted an incident and required reporting. Staff could provide examples of incidents they had reported. Data showed 79 incidents had been categorised as a near miss.

The service had no never events. Data showed there had not been any never events reported from January to December 2023. Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Managers shared learning with their staff about never events that happened elsewhere. Staff were able to tell us about incidents that may influence the care they provided.

Staff reported serious incidents clearly and in line with trust policy. From January to December 2023, the trust reported 3 serious incidents in the emergency department.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Serious incident reports we reviewed demonstrated duty of candour had been applied and the service had kept in contact with families throughout the investigation. The service monitored the carrying out of duty of candour which was reported to the board through the quality report. We reviewed the December 2023 quality report which showed duty of candour had been applied following incidents where required.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared feedback through a variety of channels such as huddles, handovers, emails and a communications folder.

Staff met to discuss the feedback and look at improvements to patient care. The emergency department daily shift report was in place and enabled senior staff to monitor daily challenges and raise incidents in a timely manner. This enabled staff to undertake theme analysis.

Clinical review meetings were scheduled monthly and mortality or morbidities including learning was discussed.

Changes were not always made as a result of feedback. For example, there had been improvements made following incidents where sepsis management was a theme. However, we were concerned the service had not fully embedded improvements in the management of patients who were detained under the Mental Health Act or who attended with mental health concerns.

Urgent and emergency services

Managers investigated incidents thoroughly. Children, young people, and their families were involved in these investigations. Managers completed root cause analysis investigations to determine how and why a patient safety incident had occurred and identified gaps in care. This approach enabled managers to identify learning and improve patient safety.

Managers debriefed and supported staff after any serious incident. Staff received regular major incident training and there was a database to record and monitor compliance. Staff received debriefs immediately following an incident from the lead consultant and senior nurse. The department had recently received funding for psychology, which meant staff could have access to trauma informed debriefs following incidents.

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Not all staff knew how to protect the rights of patients subject to the Mental Health Act 1983.

Not all staff knew how to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff had not received training and not all staff understood their responsibilities of holding patients in the department. However, staff were able to tell us how they would escalate should they not know how to manage a patient and seek advice and support from mental health colleagues.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were based on current best practice and had been revised and updated regularly. For example, they were aligned to the National Institute for Health and Care Excellence. We reviewed a sample of policies and found most were in date and referenced appropriate guidance. The service had guidelines in place for the use, storage, and maintenance of ligature cutters. Care pathways were in place for specific conditions to standardise and improve the care for children. For example, staff showed us care pathways for the management of sepsis and asthma.

The service had processes to ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Staff told us they followed the trust's equality, diversity and inclusion policy when making decisions.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. We observed a nursing staff handover huddle which identified patients who lacked mental capacity, and relatives or carers who advocated on their behalf. The requirements of patients with psychological needs were discussed including how care was to be delivered to keep them safe and reduce their anxiety.

Urgent and emergency services

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The emergency department only provided a hot meal service to patients who had been in the department for a considerable amount of time. However, sandwiches and bottle feeds were always available. Children and young people in the observation unit were provided with water and juice. Children and young people could access food from the hospital canteen. Staff advised family members about the availability of the canteen and a local shop to purchase food and drinks. In line with good practice, there was information on display in the waiting area advising patients not to consume food or drink until they had undergone triage assessment.

Nursing Care Quality Indicator (NCQI) audits completed monthly from July to December 2023, showed an average 86% compliance with hydration and nutrition standards. This was below the trust expected standards.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff had access to fluid and hydration charts in the department and used them where necessary. We saw evidence of fluid balance monitoring during our inspection, as well as hydration risk assessments.

Staff used a screening tool to monitor patients at risk of malnutrition. Patient notes we reviewed demonstrated all patients had their nutritional needs assessed on admission and further assessments carried out as necessary.

Specialist support from staff, such as dietitians and speech and language therapists, were available for patients who needed it. Staff knew how to make referrals to therapists if they were needed. These would mostly be utilised once patients moved to another area of the hospital.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff undertaking pain assessments and recording this in patient records. Staff used a pictorial face tool to assess pain in young children and those who were non-verbal. We observed posters with pain signs and various faces displayed in the department. This helped children to express their pain to staff.

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed patients receiving pain relief when it was requested. Patient records we reviewed demonstrated pain levels were monitored regularly, pain scores were recorded within the patient notes and pain relief was provided according to patient needs.

Staff prescribed, administered, and recorded pain relief accurately. We saw no errors or omissions in any medicine charts we reviewed.

The service did not monitor the average time to pain assessments and analgesia being administered. However, they undertook NCQI audits monthly from July to December 2023, these showed an average 99% compliance with pain assessment and management standards.

Patient outcomes

The service did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients.

In the 12 months prior to our inspection, there had been no requirement for the service to participate in national audits. They did not participate in the Royal College of Emergency Medicine audits, such as pain in children and infection prevention and control audits.

Managers and staff carried out a programme of repeated audits to check improvement over time. The service displayed figures for the NCQI audits. Figures for December 2023 revealed 97% for hydration, 100% for pain score, 93% for drug administration and 100% for skin assessment. However, key safety measures, such as sepsis identification and management were not routinely audited. Managers could not be assured staff were implementing best practice in relation to sepsis and provide opportunities to learn and improve to support safe and effective care and treatment.

We saw limited evidence that managers used information from the audits to improve care and treatment. There was limited evidence to demonstrate managers shared and made sure staff understood information from the audits. We reviewed service audits and saw limited evidence managers and staff used the results of audits to improve outcomes.

The service had a similar risk of re-attendance to that of the England average. The percentage of patients re-attending within 7 days was generally similar to the England and regional average from October 2021 to September 2023. From July to December 2023, the number of re-admissions within 7 days per month ranged between 2% and 11%. Since July 2023, the percentage had been increasing from 1.4% in July 2023 to 5.6% in December 2023.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Medical and registered nursing (RN) staff had the appropriate qualifications and skills to work with acutely ill children. Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The service undertook pre-recruitment checks on staff to ensure they were suitable for their role.

Managers gave all new staff a full induction tailored to their role before they started work. Student nurses told us they had been welcomed into the department and involved in the delivery of care and assessments. They showed us their induction folder, which had been signed off by their mentor, and they had access to a student folder which held information to support and enhance their clinical experience.

Urgent and emergency services

We spoke with an internationally recruited nurse who had been in post since October 2023. They received a 6-week training and worked as a band 4 nurse until they had their Nursing and Midwifery Council registration. All internationally recruited nurses were put on the preceptorship programme. Internationally recruited nurses received support from an education link worker.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided showed 88% of staff had received an appraisal.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. A band 7 professional development nurse was in post and provided robust training to staff. They organised specific emergency department training, such as triage, X-rays, clinical supervision and arranged new starter programmes and student nurse induction.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular, high-quality training which covered their learning needs. Revalidation ensured the doctors practicing in the organisation were up to date and fit to practice. Systems of appraisal and clinical governance supported the doctors with their induction, on call support and revalidation process.

The clinical educators supported the learning and development needs of staff. Triage nurses received appropriate training for Modified Manchester Triage System patient group directives to administer medicines. Staff told us the individual planned objectives were in line with the trust values and vision.

Managers identified any training needs and gave staff the time and opportunity to develop their skills and knowledge. Managers encouraged staff to develop in areas of special interest. Managers attended the ‘Management Matters’ course and leadership and development training. The senior team encouraged staff to develop their skills and knowledge. This was managed in discussion with the practice education facilitator.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw evidence of minutes from the monthly team meetings. They were comprehensive and detailed, and staff recorded they had read the notes.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Simulation training took place on Tuesdays and Thursdays. Staff picked a topic, and the scenario was carried out with learning points and interventions discussed to develop new staff and revisit competencies.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Urgent and emergency services

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Bed meetings were held 3 times a day. A site coordinator, operations manager and a lead nurse attended these meetings.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Arrangements were in place to refer children and young people to specialist services, for example, to the Child and Adolescent Mental Health Service.

An outreach team was available to support patients who had been resuscitated. The Paediatric Assessment Clinical Intervention and Education team assisted with trauma patients and staff told us this was a supportive service to work with.

The clinical decision unit assessed patients referred by their GP. Staff told us this worked well, was supported by community health services, and reduced the demand on the emergency department.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, 7 days a week. When the local x-ray facility was closed, the patients were escorted with a member of staff to the x-ray department in the main building.

Phlebotomy services for the department were always available.

At weekends, 1 consultant was on duty from 8am to 11pm, and 1 was available on call from 11pm to 8am. The consultant was supported by 3 junior and middle grade doctors from 10pm until 2am reducing to 2 doctors until 8am.

Staff had access to X-ray and computer topography imaging 24 hours a day, 7 days per week and they were not concerned about any delays in reporting or accessing results.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the emergency department. There was a perinatal mental health information board upon entering the majors area of the emergency department which included advice on post-natal depression, anxiety, advice for parents and carers and helpline information.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Assessment of a patients physical, psychological, and social needs formed part of the emergency department admissions booklet. Patients were referred to their GP for continuing support if required.

Patient education was provided through leaflets and websites to help patients make decisions on their own care in the future.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions. However, not all staff understood their responsibilities in managing patients experiencing mental ill health and under the Mental Health Act. Not all staff had received training in consent, Mental Capacity Act and Deprivation of Liberty safeguards.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patient records we reviewed had evidence of appropriate assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. We saw staff gain verbal consent prior to any treatment or procedures and saw evidence where written consent had been gained.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Not all staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 (MCA) and the Children Acts 1989 and 2004. However, they knew who to contact for advice. We saw appropriate referrals and assessment had taken place for patients presenting with acute mental health concerns.

Staff were not always clear about their responsibilities to hold a child in the emergency department who was not safe to leave the building. Staff said they would call the police if such a child attempted to leave but did not mention a clinician's ability to detain a patient under Section 5 (2) and Section 5 (4) of the Mental Health Act. This finding indicated staff had not learned lessons from a major incident in 2022 when a child attended under S17 leave and absconded from the emergency department.

Staff made sure patients consented to treatment based on all the information available. Staff we spoke with had a good understanding of the need to gain consent. Staff clearly recorded consent in the patients' records. Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. Staff had a clear understanding of what Gillick competence meant. Gillick competence is a term used in medical law to decide whether a child (a person under 16 years of age) can consent to their own medical treatment, without the need for parental permission or knowledge.

Nursing staff received and kept up to date with training in the MCA and Deprivation of Liberty Safeguards (DoLS). Data showed 98% of RNs were up to date with MCA and DoLS training.

Medical staff were not up to date with MCA and DoLS training. Data showed 59% of senior medical staff and 40% of trust grade medical staff had completed this training.

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. There was a mental health liaison team who advised on mental health issues.

Managers did not monitor how well the service followed the MCA and made changes to practice when necessary.

Urgent and emergency services

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a ward round and the consultant used plain language to communicate with the parents. They discussed counselling options, changing antibiotics to oral and listened and responded to parents' queries with full explanation.

Staff followed policy to keep patient care and treatment confidential. We observed curtains being closed when staff were carrying out treatments or meeting patients personal care needs.

Patients said staff treated them well and with kindness. Parents we spoke with felt staff were polite, 'lovely' and provided them with the information they required. We observed staff treating patients and saw they were kind, caring and compassionate to the patient and their family members. All staff were respectful to those they were caring for.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. For example, a consultant involved a child in all discussions and then spoke with the parents. We spoke with the parents after this review, and they could not speak more highly of the care and treatment from the medical staff. They felt they really did care.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. A multi faith chaplaincy team was available to provide religious spiritual and pastoral care within the hospital. The team was available on weekdays from 8am to 4pm and on call for emergencies at other times.

A Christian chapel, Muslim prayer room and a meditation room were available on the main entrance.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. A family room was available and used for bereavement and women who needed to breastfeed their babies.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Urgent and emergency services

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The service had a relative's room which was used for breaking bad news and for grieving relatives.

Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them.

The chaplaincy team offered spiritual support for children, young people and families of all religious beliefs and those with no particular belief at all. The multi-faith team brought activities to children and offered a listening ear during difficult times.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback was not always positive. The service participated in the Friends and Family Test survey. Data showed the number of people who completed this was low. It ranged from 16 responses in July 2023, to 34 responses in December 2023. From July to December 2023, a total of 144 people had responded, with an average of 69% reporting they would recommend the service to friends and family. In December 2023, this dropped to only 59% of respondents saying they would recommend the service.

Staff supported patients to make informed decisions about their care. Doctors and nurses explained to patients and their relative's alternatives to treatments when these were available.

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Waiting and treatment times were monitored and compared to national standards. There were systems to manage the flow of patients through the emergency department and to discharge or to admit patients to the hospital. Senior managers could view the length of time each patient had been in the department, and what they were waiting for, including speciality reviews or bed admissions. The system displayed the number of patients arriving at the emergency department by ambulances and by walk in. The data was discussed at bed meetings multiple times a day.

Facilities and premises were not always appropriate for the services being delivered. The was no mental health assessment room and staff did not always have sight of all patients in the department. Plans were underway to regenerate the hospital site including the emergency department.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems and learning disabilities. Child and adolescent mental health services were available with a crisis team available out of hours.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had signed up to Mencap's "Getting it right" charter to show commitment to improving healthcare and treatment for children and young people with learning disabilities.

There were processes to safely manage patients requiring emergency care with complex needs. For example, children living with cancer who needed to see a doctor were brought into the department after 4pm. They received a call from the cancer team who ensured they came in with cards to show they were currently receiving cancer treatment. This provided staff with a better understanding of their needs to support safe management of the patient.

A learning disability liaison nurse was in post and worked with trained staff to ensure the needs of patients were met. They were responsible for co-ordinating appropriate care with everyone involved in treating the patient with learning disabilities.

The service relieved pressure on other departments when they could treat patients in a day. For example, the GP service, overseen by the trust saw patients who would otherwise have been seen in the emergency department. This helped to improve the time staff in the emergency department had to provide care for acutely unwell patients.

Meeting people's individual needs

The service was inclusive but did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and autism, received the necessary care to meet all their needs. The department was not designed to meet the needs of children living with complex medical needs. For example, there was no segregated play area for various age groups. The environment was bright and noisy and there was no environmental provision for children with sensory needs, learning disability and autism. Following our inspection, the trust updated us to advise play equipment had been ordered and the constraints recognized with the estate would be resolved upon completion of the new elective care hub by March 2025.

Children had behaviour support plans in their records which included sensory strategies. These were however, written by external providers and copied into the notes. There was no evidence that staff were following the care plans.

A new 'STICK express' policy allowed anxious children to go home with a referral to a Child and Adolescent Mental Health Service in place, so the crisis team could assess them at home. Staff conducted a risk assessment and gave parents the contact details for the Forward-Thinking Birmingham service.

Staff used a mental health pro forma when treating children with mental health needs. This meant they were able to easily identify what specific mental health support was required, rather than just asking the crisis team to attend.

Urgent and emergency services

There was a play therapist who worked across the emergency department, paediatric assessment unit and the high dependency unit.

A support hub was available for young people in need especially young children who had been or who were at risk of gang crimes. A youth intervention programme was also in place to support children and young people establish lifestyle changes following a crime.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The emergency department had sensory kits in the minors' cubicles, but they were limited by their physical space to use them effectively.

The service had information leaflets available in languages spoken by the patients and local community. Cubicles in the annexe area had quick response codes which enabled patients access information on different conditions in a variety of languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. An interpreting service was available for both patients and staff. Staff could also use an interpreting telephone service.

Patients were given a choice of food and drink to meet their cultural and religious preferences. This was mainly sandwiches, plus toast and cereals at breakfast time. Staff said they could access hot food on an individual basis if required.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to resources to help them communicate with patients with additional or complex needs relating to autism or learning disabilities.

The annexe area had a board which provided information on burns and scalds, pain management and minor injuries. General information was available on the patient's journey through the emergency department which included, the journey from registering with a receptionist and triage assessment by a triage nurse. Patients were then placed into categories such as red for very unwell patients, orange for patients who needed to be seen within 10 minutes, yellow for patients who needed to be seen within an hour and green for patients who needed to be seen as soon as possible.

Access and flow

People could generally access the service when they needed it but did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The trust's median time from arrival to initial assessment was consistently shorter (better) than the national average from October 2021 to September 2023, ranging between 2 and 4 minutes. In contrast, the average median time to initial assessment in England ranged between 8 and 11 minutes throughout the 24-month period.

At the time of our inspection, the service was under considerable pressure due to demand, and the average time to triage and first set of observations was 16 minutes. Furthermore, the average time to be assessed by a doctor was 149 minutes which was longer than the national standard of 60 minutes.

Urgent and emergency services

The number of patients seen, treated and admitted within 4 hours of arrival performance varied. From October 2021 to September 2023, the service time to treatment figures showed fluctuations both above and below the England average, with 15 out of the total 24 months reporting higher (worse) values than the average. There was a notable upward trend for the trust from August 2022 to December 2022, reaching a peak median time to treatment of 2 hours 20 minutes. However, from July to September 2023, the service figures dropped below the England average, with the lowest median time to treatment occurring in August 2023 at 40 minutes.

The percentage of patients admitted, transferred, or discharged within 4 hours of arrival were consistently higher (better) than the national and regional average. In October 2023, the data indicated that the trust successfully met the 4-hour threshold for 74.9% of patients.

The trust consistently achieved a 0% rate of patients waiting more than 4 hours from the decision to admit to admission, spanning from November 2021 to October 2023. This contrasted with the regional average, which fluctuated between 33% and 47% during the same period.

There were no instances of patients waiting over 12 hours for admission from the decision to admit. Figures were consistently recorded as 0% from November 2021 to October 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. The median total time in the department was consistently shorter (better) than the England average from November 2021 to September 2023. In the 9 months prior to our inspection, figures fluctuated between 1 hour 56 minutes and 2 hours 34 minutes.

In quarter 4 of 2023/24, the trust achieved over 80% performance against the national four-hour standard which was above (better than) the NHS England interim trajectory of 76%. It achieved more than 90% of ambulance handovers within 30 minutes in the second half of 2023/24 which was the national guidance target time.

The number of patients leaving the service before being seen for treatments was increasing. Between October 2021 and September 2023, the trust mostly maintained a similar or lower (better) percentage of patients leaving before being seen when compared to the national and regional average. The exceptions to this trend were observed in October 2021, November 2022, and December 2022, when there was a sudden increase in the percentage.

From July to December 2023, the percentage of patients leaving before being seen had been gradually increasing. For example, in July 2023, 2.4% of patients left without being seen which increased to 10.6% in December 2023. The service undertook a review of this and found the main reason for leaving was long waits to be seen by a doctor. The data showed over this time period, the time to be seen by a doctor also increased. In response the service implemented some initiatives to improve this. For example, making better use of clinical space and moving those assessed as safe to wait back to a designated space in the waiting area. This meant that patients waiting could be seen quicker rather than waiting for a space in the department.

The service percentage of patients that reattended the department within 7 days of a previous attendance was generally similar to the England and regional average from October 2021 to September 2023.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Urgent and emergency services

Patients, relatives and carers knew how to complain or raise concerns. The emergency department waiting areas and the trust’s website had information on how to make a complaint. Complainants received an acknowledgement within 3 working days of making a complaint. An investigating officer made contact to discuss the concern in detail and agreed on a reasonable timescale to respond to the complaint.

The service clearly displayed information about how to raise a concern in patient areas. This was seen during the inspection.

Staff understood the policy on complaints and knew how to handle them. Data provided to us following our inspection showed from July to December 2023, the service received 10 formal complaints. All complaints had been acknowledged and investigations had commenced. One was outside of trust timescales; however, this was impacted by external factors.

Managers investigated complaints and identified themes. There was a consultant who took a lead on governance including complaint management. The consultant ensured all complaints had been appropriately investigated, identifying themes and learning which was shared with staff.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Feedback from complaints was shared with staff and learning was used to improve the service. Themes were shared with staff during team meetings, huddles and at daily handovers.

Is the service well-led?

Requires Improvement

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

Leadership

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

Leaders had the skills, knowledge and experience and integrity that they needed to run the service. The department was led by a head of nursing and supported by a clinical and governance lead, and a consultant. The head of nursing was supported by ward managers to lead day to day activity. Consultants and specialist doctors engaged with nursing staff which demonstrated an effective leadership team. They worked well together as a team and understood the challenges to quality and sustainability and how to address them. For example, during our inspection, the leadership team provided an overview of how they took quick action to address a measles outbreak in the area. They worked together to ensure the service was prepared and safe.

The service met The Royal College of Paediatrics and Child Health (RCPCH) recommendation to have a Paediatric Emergency Medicine (PEM) consultant with dedicated session time allocated to paediatrics. The PEM role supports the service to self-assess against RCPCH standards and implement improvements accordingly.

Urgent and emergency services

Leaders understood the challenges to quality and sustainability, and they were able to identify the actions needed to address them. Managers were aware of the challenges to recruit suitably qualified staff within a paediatric emergency department. They told us they had a programme in place to grow their own staff. For example, from a nursing perspective they had developed opportunities for progression such as embedding nurse associate roles and advanced nurse practitioner roles to support the medical workforce. Staff told us these roles led to increased quality and strengthened the skills within the department, at the same time providing opportunities for progression to retain staff.

Furthermore, leaders were aware improvements were required in relation to management of patients with mental health needs. As a result, they submitted a business case to recruit a mental health educator within the department to support training, development and to support the management of complex patients.

Clinical leads had increased the number of consultants to improve clinical leadership and governance. Clinical leads considered they were in a strong position now to develop the service clinically and ensure consultants had lead roles and opportunities to improve clinical effectiveness, something which they have struggled to embed due to capacity. Furthermore, the increase in consultants has provided more opportunities for trainees and development of PEMs.

We saw service leaders and managers were visible in clinical areas. Consultants were visible to support more junior doctors.

There were lead roles within the service. For example, there were mental health champions and a quality improvement project looking at management of sepsis.

Vision and Strategy

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

There was a clear vision and a set of values, with quality and sustainability as the top priorities. An urgent and critical care strategy was in the process of being developed which would align with the trust vision and strategies. There were 7 key priorities identified which included growing people, access to treatment at the right time, having an impact. Investing in technology, creating the best environment, improving health through research and working in partnership.

The emergency department's vision mirrored the trust-wide vision to provide a world-leading care to patients with the mission to provide outstanding care and treatment, to share and spread new knowledge and practice, and to always be at the forefront of what is possible.

The strategic goals had linked priority themes such as developing partnerships with purpose, attracting and retaining talent, recovering waiting times, delivering research and innovation and embedding clinical outcomes.

The strategy aligned to local plans in the wider health and social care economy and set out how they planned to meet the needs of the relevant population. The strategy also included their target populations including those most deprived, areas of health inequalities, such as asthma, diabetes, epilepsy, oral health and mental health to support integrated care. The strategy outlined a road map of what it wanted to achieve and how it would turn the strategy into action. There were 2 main workstreams that at the time of our inspection were underway.

Urgent and emergency services

The department met the standards set out by the RCPCH standards for children in emergency care settings. For example, staff receiving children in urgent care had appropriate paediatric competencies.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff in the department felt valued by one another. We observed staff working well together, knew each other well, and were supportive and kind. Staff felt supported, respected, valued and were positive and proud to work in the organisation.

Staff interacted with each other respectfully and professionally. Nursing staff told us they felt able to speak up when they had concerns and that managers listened to them and helped find ways to resolve problems.

There were opportunities for career development. We were given examples of individual members of staff being encouraged and supported to develop within their careers. Staff told us that managers were always prepared to help with development. The service had introduced nurse associates which provided health care support workers with opportunities to work towards a qualification and develop their skills. There were opportunities for them also to top up courses to become registered nurses. Registered nurses also had opportunities for lead roles and also more enhanced roles, such as enhanced and advanced nurse practitioners which support the medical workforce also.

Junior doctors felt their practice was adequately supervised by an appropriately experienced clinician. They told us they had opportunities to learn how to provide safe care from observation of their seniors.

Action was taken to address behaviour and performance that was consistent with the vision and values. We observed robust process for managing sickness and return to work. Managers held informal meetings with staff involved and made necessary referrals to human resources and occupational health.

The culture encouraged openness and honesty at all levels. Staff were able and encouraged to report incidents and make suggestions. They all reported being taken seriously and that their views were considered as valid as more senior staff. Service leaders had full oversight of duty of candour processes to ensure patients, parents and carers had a full explanation and apology where things went wrong. We saw managers monitored progress with on-going duty of candour at monthly assurance meetings.

There were appropriate security arrangements to keep staff and others safe and protected from violence, particularly at weekends and out of hours. Staff told us they occasionally had intoxicated adults in attendance at weekends and received support from security. Staff safety was discussed at monthly managers meetings.

Whilst improvements to the management of patients with acute mental health conditions required improvement, we saw staff had good oversight of patients who needed extra emotional support. These patients were discussed at handovers, and we saw they were supported.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Arrangements were in place with partners and third-party providers, but these were not always effective.

Urgent and emergency services

The lack of auditing of sepsis by the service suggested a lack of oversight and the potential for ongoing unmanaged risk. Due to the lack of scrutiny and lack of oversight in regard to risks, we were not assured that robust governance processes were in place. We were also not assured that poor performance was fully sighted by the board, due to the lack of pace to drive improvement. Following our inspection, the trust confirmed it was reviewing the audit programme and would include a schedule for regular sepsis auditing.

Governance structures were in place to effectively manage performance between services within the hospital and with external providers.

The service had a governance lead clinician who had full oversight of governance processes, quality, and safety issues. All staff complimented the leadership provided in embedding governance processes. For example, there were improvements in complaint handling within the department and investigation of serious incidents.

Governance issues were discussed in departmental meetings and the urgent and critical care clinical group, of which the emergency department was part. They sent quarterly reports to the Children's Services Quality Assurance Committee. This committee reported to the Board Quality Committee through the Key Issues and Assurance Report. The service jointly produced a quarterly quality and safety performance report with the critical care team. The report provided and overview of key quality and safety indicators. It was shared with the trust board through the clinical and safety quality assurance committee.

Leaders and senior staff discussed incidents, complaints, performance, and risks during a monthly emergency department management meeting. This was further enhanced by the monthly clinical governance meetings. We reviewed meeting minutes from October to December 2023, which showed good attendance and input.

Senior leaders explained that the executive board were well sighted on the challenges facing the emergency department and there were good lines of communication, that the board listened, and would take immediate action to support the department although they did not always have the means to provide a solution. For example, the service recognised pressures in securing mental health training and presented a business case to the board to secure staff training.

Staff at all levels were clear about their roles and responsibilities. They worked well together, and we observed a mutual respect between different professions and staff and management.

Arrangements with partners and third-party providers were not always effective. Service level agreements (SLA) were in place with Child and Adolescent Mental Health Services to support the assessment and transfer of patients attending the department. However, the agreements in place were limited and did not provide the service effective support outside of normal working hours.

The service had SLAs in place with local ambulance services which they used to transfer mental health patients. Managers told us as their staff were not trained in restraint, they occasionally booked a local service to provide enhanced supervision and manage any restraint practice.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Urgent and emergency services

Systems and processes for monitoring service safety, performance and quality were not always effective. Managers completed a programme of internal audit to monitor quality and operational processes. Audit measures included for example, assessing standards for documentation, the environment, infection prevention and control, fluid balance monitoring and medicines management. However, managers told us they did not have an audit to measure performance against sepsis screening and treatment standards in paediatrics.

Learning from incidents was not always embedded. For example, we found learning from a serious incident involving a patient who was at risk and absconded had not been acted on to avoid it reoccurring. However, we saw incidents were analysed and themes identified through monthly quality reports. These were shared with staff.

There were processes to identify and escalate risks and issues and the service had a risk register. At the time of our inspection there were 6 risks on the risk register. Risks reflected some of the concerns we found, such as gaps in the pathway for Child and Adolescent Mental Health Service and the risk of children not receiving timely intervention. We saw these were regularly reviewed at management meetings and were presented to the quality assurance committee.

The service had plans to cope with the unexpected. There were plans in place to manage outbreaks, including measles. The service undertook skills drills to deal with specific emergency/trauma scenarios which may arise.

Information Management

The service did not always collect reliable data to enable them to analyse it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were not all integrated but were secure. Data or notifications were consistently submitted to external organisations as required.

Information management systems were not always used effectively to monitor and improve the quality of care and performance. For example, the service did not record or have oversight of use of sedation and rapid tranquilisation. Furthermore, the service did not have oversight of performance against time to first consultant review or time to pain assessment and analgesia being given. Managers told us systems did not allow them to extract this data but were in the process of implementing a new system which would support oversight of key safety and performance measures. This meant the service did not always have oversight of key information to ensure the service was performing.

Staff working in the acute hospital could not access the mental health team's shared electronic database. This meant they could not search for previous mental health history.

The service was working towards the introduction of a new information technology software system which would enhance electronic recording. The chief clinical information officer had put in a business case and a nurse had been seconded to work on the project.

Senior staff shared key messages via email. Staff shared key messages, such as the use of personal protective equipment, any staffing issues and the theme of the week during handover.

We observed computer screens being on inactive mode when not in use and staff swiped in an out in majors and resus areas.

Processes were in place to ensure the service notified relevant external organisation of any incidents where required.

Urgent and emergency services

The department met the standards set out by the RCPCH. For example, in line with standard 55 and 56, the service implemented a plan to manage a local outbreak of measles. They liaised with other local services and set up a project team to have oversight of the outbreak and how they would ensure all children who could present at the department would be managed to reduce risk.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Peoples' views and experiences were gathered and acted on to shape and improve the service. Patients and relatives were asked to leave feedback on cards in the department, by downloading the 'feedback app' or by using a QR code to leave their comments. The service participated in the Friends and Family Test survey but the number of people who completed this was low.

Staff were actively engaged so that their views were reflected in the planning and delivery of the service and culture. There was a staff experience group (SEG) which met 6 weekly and was a forum to discuss all staff experience matters including the staff survey results and associated action plans. The staff survey was divisionally led, and results were discussed at the SEG in April and May 2023 with an agreement to focus on 3 main areas such as recognition and reward, staff voice and learning.

Staff morale and wellbeing had been a key concern raised via SEG. There was an action to support staff with existing wellbeing resources. Senior staff had identified an online tool to support wellbeing and at the time of our inspection was trailing its effectiveness with trainees.

Service leaders liaised with the 'healthy minds' service to identify a psychologist to help with well-being. They worked with teams to review patient experience and ensured staff were aware of when positive feedback had been left by patients to enable them to feel valued and recognised.

The Birmingham Children's Hospital website held a wealth of information including a virtual tour of the site to show to children and alleviate anxieties. The website was child friendly and easy to use.

The service collaborated with partner organisations to help improve services for patients. For example, staff worked with other stakeholders to confirm priorities in relevant specialties, such as mental health services.

Learning, continuous improvement and innovation

Staff were committed to embedding a model of continual learning and improvement, although implementation of quality and safety improvements was not always timely. They recognised areas for improvement. They had a good understanding of quality improvement methods and the skills to use them. However, leaders did not always encourage innovation and participation in research.

Leaders were striving to improve and continually learn. The consultant body had increased which supported the service to maintain clinical responsibilities and involvement in research and clinical effectiveness projects. For example, a consultant had led a team to improve the identification and treatment of sepsis by implementing an improved triage system to identify the sickest and most at risk of sepsis patients more effectively.

Urgent and emergency services

Managers recognised further improvements were needed to fully embed a continual learning culture. For example, the service had not participated in any recent national audits for emergency medicine. The service was not checking standards were being followed through audit in line with sepsis best practice. There were sometimes delays in acting on areas of concern such as the management of patients at risk of self-harm or with mental health concerns in the department.

Systems were in place to review mortality and morbidity with good engagement.

Standardised improvement tools and methods were used. The trust had taken the national and system level approach to reducing healthcare inequalities for children and young people. The service had implemented a national programme to support the reduction of health inequalities called the 'Core20 plus5' approach. This approach focuses on the most deprived 20% of the population plus specific population groups to focus campaigns and improvement. The key clinical areas identified by the service included asthma, diabetes, epilepsy, oral health, and mental health.