

Birmingham Women's and Children's NHS Foundation Trust

Inspection report

Birmingham Children's Hospital
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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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

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.

Summary of findings

Background to the trust

Birmingham Children's Hospital launched the community mental health service as lead partner of Forward Thinking Birmingham (FTB) in April 2016.

Birmingham Women's and Children's NHS Foundation Trust was formed in February 2017 when Birmingham Children's Hospital acquired Birmingham Women's Hospital.

Forward Thinking Birmingham expanded in April 2018 with the acquisition of the community mental health services for 18 to 25 year olds and the early intervention mental health services.

- **Birmingham Women's Hospital:**

Birmingham Women's Hospital is one of only two dedicated women's hospitals in the UK. The hospital provides specialist services to more than 50,000 women, men and their families every year from Birmingham, the wider region and beyond.

The hospital offers a full range of gynaecological, maternity and neonatal care. The hospital also offers fertility and fetal medicine services. The fetal medicine centre receives regional and national referrals and is home to the West Midlands Regional Genetics Laboratory.

- **Birmingham Children's Hospital:**

Birmingham Children's Hospital is a specialist paediatric centre, caring for children and young people up to the age of 16.

The hospital has a national liver and small bowel transplant centre and is a global centre of excellence for complex heart conditions, the treatment of burns, cancer and liver and kidney disease.

The hospital is a nationally designated specialist centre for epilepsy surgery and is also a paediatric major trauma centre for the West Midlands.

The trust is also home to one of the largest Child and Adolescent Mental Health Services in the country, with a dedicated inpatient eating disorder unit and acute assessment unit for regional referrals of children and young people with the most serious of problems (Tier 4), and the Forward Thinking Birmingham community mental health service for 0-25 year olds.

(Source: Trust website)

Birmingham Children's Hospital equates for approximately 55% of patients and 58% of staff, Birmingham Women's Hospital equates for approximately 36% of patients and 33% of staff, Forward Thinking Birmingham equates for approximately 9% of patients and 8% of staff.

Overall summary

Our rating of this trust went down since our last inspection. We rated it as **Good**  

What this trust does

- **Birmingham Women's Hospital:**

Summary of findings

Birmingham Women's Hospital is one of only two dedicated women's hospitals in the UK. The hospital provides specialist services to more than 50,000 women, men and their families every year from Birmingham, the wider region and beyond.

The hospital offers a full range of gynaecological, maternity and neonatal care. The hospital also offers fertility and fetal medicine services. The fetal medicine centre receives regional and national referrals and is home to the West Midlands Regional Genetics Laboratory.

- **Birmingham Children's Hospital:**

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The hospital has a national liver and small bowel transplant centre and is a global centre of excellence for complex heart conditions, the treatment of burns, cancer and liver and kidney disease.

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The trust is also home to one of the largest Child and Adolescent Mental Health Services in the country, with a dedicated inpatient eating disorder unit and acute assessment unit for regional referrals of children and young people with the most serious of problems (Tier 4), and the Forward Thinking Birmingham community mental health service for 0-25 year olds.

(Source: Trust website)

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 2 and 23 April 2019, we inspected the core services of Surgery at Birmingham Children's Hospital, Maternity Inpatients, Maternity Community, Neonates, Gynaecology and Diagnostic Imaging at Birmingham Women's Hospital and Community Child and Adolescent Mental Health Services, Crisis and Health Based Place of Safety and Early Intervention Psychosis as part of Forward Thinking Birmingham.

What we found

Overall trust

Our rating of the trust went down. We rated it as good because:

Summary of findings

- Forward Thinking Birmingham was rated as requires improvement overall. Of the core services inspected in April, one core service was rated requires improvement overall and two core services were rated as good overall.
- Birmingham Women's Hospital was rated as good overall. Of the core services inspected in April, one core service was rated requires improvement overall and four core services were rated as good overall.
- Birmingham Children's Hospital was rated as outstanding overall, Surgery was inspected in April and caring was rated as outstanding.

Our full inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website – www.cqc.org.uk/provider/RQ3/reports.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Two core services at Birmingham Women's Hospital and one core service within Forward Thinking Birmingham were rated as requires improvement for safe.
- Three core services at Birmingham Women's Hospital, the core service at Birmingham Children's Hospital and two core services within Forward Thinking Birmingham were rated as good for safe.

Are services effective?

Our rating of effective went down. We rated it as good because:

- Four core services within Birmingham Women's Hospital, the one at Birmingham Children's Hospital and one within Forward Thinking Birmingham were rated as good for effective.
- Two core services within Forward Thinking Birmingham were rated as requires improvement for effective.
- Diagnostic Imaging is not rated for effective.

Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- Surgery at Birmingham Children's Hospital was rated as outstanding for caring.
- Four core services at Birmingham Women's Hospital and three core services within Forward Thinking Birmingham were rated as good for caring.
- One core service at Birmingham Women's Hospital was rated as requires improvement for caring.

Are services responsive?

Our rating of responsive went down. We rated it as good because:

- The core service at Birmingham Children's Hospital, all core services at Birmingham Women's Hospital and one core service within Forward Thinking Birmingham were rated as good for responsive.
- Two core services within Forward Thinking Birmingham were rated as requires improvement for responsive.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Surgery at Birmingham Children's Hospital, four core services at Birmingham Women's Hospital and two core services within Forward Thinking Birmingham were rated as good for well-led.

Summary of findings

- One core service within Forward Thinking Birmingham was rated as requires improvement for well-led.
- One core service at Birmingham Women's Hospital was rated as inadequate for well-led.

Ratings tables

The ratings tables show the ratings overall and for each key section, for service, hospital and service type, and for the whole trust. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in at trustwide level, within surgery at Birmingham Children's Hospital, maternity inpatients, gynaecology, neonates and diagnostic imaging at Birmingham Women's Hospital and Specialist Community Mental Health Services for Children and Young People within Forward Thinking Birmingham.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 14 breaches of legal requirements that the trust must put right. We found 59 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued five requirement notices to the trust. Our action related to breaches of one legal requirements at a trust-wide level and five in four core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Trustwide

- Governance arrangements were proactively reviewed and reflected best practice.
- The Learning from Excellence reporting process offered a high value approach to ensuring trust wide learning from excellence.
- Staff demonstrated an overwhelming sense of pride to work for the trust, to ensure compassionate care for women, children and young people and families of Birmingham was offered. We saw this lived through value driven approaches.
- Leaders actively promoted staff empowerment to drive improvement, with a strong focus on the needs and experiences of patients. This promoted a culture of collective responsibility for openness and transparency.

Summary of findings

- There was a strong focus on patient experience and involvement to shape and improve care. We saw excellent examples of dynamic and forward-thinking solutions to secure service accessibility.

Surgery at Birmingham Children's Hospital

- Services were actively engaged in multiple research projects with other agencies and partners to help to shape and improve future care. Including the development of lab grown biopsy tissue and liver and small bowel transplants.
- Divisional staff were actively supported to be involved in local projects to improve patient care. For example, supporting the move of paediatric orthopaedic services from a local hospital to the trust to improve access to services and improved outcomes.
- An effective staff training programme including supporting patients with high dependency needs meant less surgical patients required to be supported in a dedicated high dependency unit or intensive care ward and could remain on wards with staff they were familiar with.
- The service employed clinicians with the skills and expertise to sustain and develop a national and international centre of excellence through the implementation of innovative and ground-breaking practices. This included staff with worldwide reputations in hepatology and burns specialties.
- The service had an open and positive culture that placed babies, children and young people at the heart of everything they did. Staff went out of their way to support patients who were already familiar with them and gave up their own time to support patients and families engage in social events.
- Staff had developed innovative techniques which supported patients and families to understand their care plan and express their views. Staff in the play centre used a dolls house to explain where young children where they would stay when they were admitted to the hospital.
- Staff went to exceptional efforts to support a family who had been involved in a car accident and were being supported at different hospitals to meet up.
- The burns service found innovative ways of promoting the dangers of fires within the local community. They worked with the local fire brigade to launch an awareness campaign of the dangers of burns at bonfire night and Diwali.
- The introduction of a revised fasting policy which greatly reduced the time patients were required to be nil by mouth prior to surgery.
- Mothers, who wanted to, were supported to express milk even when they were away from their child.
- Reviews of care pathways had improved patient outcomes. This included reducing the time patients needed to be starved prior to surgery and the number of delayed operations. Some surgical procedures which required the patient to be admitted for three days were now safely performed as day cases.

Maternity Inpatients at Birmingham Women's Hospital

- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for women with multiple and complex needs. The fetal medicine service provided specialist care for the region and wider areas and there was an ongoing research programme in the service which all staff we spoke with were engaged with.
- There was a new obstetric waiting lounge which afforded women the opportunity to wait for their planned procedures away from the delivery suite and inpatient ward areas.

Gynaecology at Birmingham Women's Hospital

Summary of findings

- The safeguarding team was very proactive in their approach to providing support and care for women and their families using the hospital services. They had worked well in ensuring a consistent regional approach to practice and learning lessons.
- The safeguarding team had given real thought to ensure the needs of vulnerable groups of people were highlighted to staff at the hospital. This included providing face to face workshops in child sexual exploitation, female genital mutilation, domestic violence, learning disabilities and autism in addition to the mandated training. The work they had done around domestic violence, including the implementation of a comprehensive domestic abuse pathway was impressive.
- The work that had gone into improving the termination of pregnancy service had resulted in turning the service round for the better. Staff were dedicated to providing a non-judgemental service to women using the service. They showed great compassion and emotional support for women, their partners and foetuses when signs of life were observed.
- The implementation of Fika Fridays was a positive addition to improving the culture within the service. The service had been cited by the Royal College of Gynaecology (RCOG) and a team member had been picked to be the national lead for bullying at the RCOG as a result of Fika Fridays. They had also been recognised by the NHS leadership academy for the initiative.
- Staff were actively engaged with professional bodies and had helped develop national competencies within some of the subspecialties. For example, the menopause service.
- The hospital had a proactive bereavement team that attended safety huddles on wards to ensure they were involved in providing emotional support at the earliest opportunity.
- There were designated cuddle nurses within the termination of pregnancy service, to provide palliative care for foetuses that had shown signs of life. Their role was to provide comfort and cuddles to the foetus in a calm and soothing environment until signs of life ceased.
- Staff within gynaecology had attended women with additional needs in their home environments, to explain procedures in pictorial formats before the women arrived at the hospital. They also arranged for women with additional needs to have tours around the wards and theatres before admission. This allowed women to process what was going to happen and ensured they were comfortable and at ease in the environment on admission.

Neonatal services at Birmingham Women's Hospital

- We saw some examples of staff providing outstanding care. This included occasions where; a nurse came on duty when they were not on the rota at the request of a family to help deliver end of life care to a neonate and a nurse who gave a mother of a neonate some clothes and toiletries as they had limited social support system in place.

Diagnostic Imaging at Birmingham Women's Hospital

- The EPAU safeguarding lead had implemented a range of new safeguarding strategies and embedded new standards of care. This had led staff to identify 25 previously undetected safeguarding needs of patients at risk, including those at extreme risk of abuse or exploitation. Standards of practice were audited to ensure consistency.
- The EPAU team had worked with the learning disabilities team to introduce new, bespoke resources for patients. This included adapted documentation for patients living with a learning disability or a mental health need and a pictorial information guide for patients with a learning disability who had experienced a miscarriage or serious complication.
- A midwife sonographer was leading a new audit to assess the quality of scan images taken during first trimester screening in the EPAU and this reflected practice that exceeded national minimum standards.

Specialist Community Mental Health Services for Children and Young People (Forward Thinking Birmingham)

Summary of findings

- Psychotherapy staff continued to support patients who required an inpatient stay in the local area. They ensured patients were able to continue with their therapy.
- The service was involved in a wide range of research and had strong links with local academic institutions.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with two legal requirements. These actions related trustwide, and one core service.

Trustwide

- The trust must ensure that all data collected centrally is an accurate reflection of the services provided, so as assurance can be sought at trust level. This includes mandatory training data. Regulation 17 (2) (d) (ii)

Gynaecology

- The service must ensure there is adequate oversight to assess, monitor and mitigate risks. Regulation 17 (2) (b)

Diagnostic Imaging at Birmingham Women's Hospital

- The service must ensure the radiation protection advisor carries out an annual audit of the x-ray facility. Regulation 17 (2) (b)
- The service must ensure all staff have documented, up to date clinical competencies. Regulation 18 (2) (c)
- The service must ensure there is adequate oversight and effective governance systems in place to assess, monitor and drive improvements in the quality and safety of the diagnostic imaging services provided. Regulation 17 (1)

Mental Health Crisis Services and Health Based Place of Safety (Forward Thinking Birmingham)

- The trust must improve recording of information relating to the Mental Health Act in the health-based place of safety including the starting time of the detention of each patient. Regulation 17 (2) (c)

Community-Based Mental Health Services of Adults of Working Age (Early Intervention Psychosis Team, Forward Thinking Birmingham)

- The service must ensure there are enough rooms available to ensure that staff can undertake appointments with patients on time and in a suitable environment. Regulation 15 (1) (c)

Specialist Community Mental Health Services for Children and Young People (Forward Thinking Birmingham)

- The trust must ensure that there are sufficient numbers of skilled and qualified staff to provide a safe, effective and responsive service. (Regulation 18 (1))
- The trust must ensure that staff working in the service are supported effectively to reduce the negative impact on their wellbeing. (Regulation 18 (2)(a))
- The trust must ensure the continued improvement of patient records. This includes ensuring that patient information is up-to-date and accessible to staff when they need it. (Regulation 17 (1) (2) (c)(f))

Summary of findings

- The trust must continue to reduce the impact of patient waiting lists, working with local partners in the health and social care community to ensure patients who need help receive it in a timely manner. (Regulation 17 (1) (2) (a) (b) (f))
- The trust must ensure all young people are offered a copy of their care plan. (Regulation 9 (3) (g))
- The trust must ensure that physical health checks are carried out for all patients requiring them and any support for ongoing physical healthcare is clearly identified in the patient record. (Regulation 12(1)(2) (a)(b))
- The trust must ensure they review and identify actions to improve the number of available rooms for patient consultations and the quality of both soundproofing and temperature control within these rooms. (Regulation 15 (1) (c))

Action the trust SHOULD take to improve

Trustwide

- The trust should ensure the potential strategic risks regarding the actions needed to take the equality, diversity, human rights and inclusion agenda are reflected appropriately.
- The trust should continue to risk assess and review all policies that are out of date or due to expire.

Surgery at Birmingham Children's Hospital

- The service should ensure medicine boxes are secure and regularly checked for out of date medicines.
- The service should ensure they have systems which ensure patient records, on the neonatal surgical ward, are fully completed and legible.
- The service should continue to take action to ensure the mandatory training target is met within the 12-month deadline.
- Neonatal services at Birmingham Children's Hospital should attend joint neonatal meetings, with Birmingham Women's Hospital to share learning and compare performance.

Maternity Inpatients at Birmingham Women's Hospital

- The service should ensure that there are robust processes in place to monitor infection prevention and control processes, including the completion of cleaning audits.
- The service should ensure dirty utility areas and rooms where cleaning detergents are stored are securely locked.
- The service should ensure fridge temperatures are consistently recorded in line with trust policy, and that appropriate action is taken when they are out of range.
- The service should ensure daily checklists for emergency equipment are completed.
- The service should ensure participation in national audits provides robust evidence that allows meaningful comparison of their patient outcomes.

Gynaecology at Birmingham Women's Hospital

- The service should ensure all Automated Electronic Devices (AEDs) are consistently checked regularly.
- The service should continue to embed the process for managing and recording the storing and transferring of clinical specimens.
- The service should ensure all areas containing patient confidential information, tissue samples and hazardous substances are not accessible to unauthorised people.

Summary of findings

- The service should continue to embed the new system for consistent daily safety checks of ward 7 in line with ward 8, including medicine audits.
- The service should continue with reviewing the nursing model to ensure that staffing levels remain safe with the increase in demand for services.
- The service should continue to source new models of working to help the medical workforce with the increased demand on services.
- The service should continue to ensure consultant annual leave is sufficiently covered so it does not impact the ability to run services safely.
- The service should continue to implement a record audit to cover areas of improvement identified on inspection.
- The service should ensure patient records are filed appropriately and in correct records to ensure confidentiality is maintained and to ensure staff have all relevant information to provide care and treatment.
- The service should continue to identify and develop key gynaecology specific clinical outcome performance indicators for reporting to the board and externally.
- The service should consider developing formal key performance indicators for the helpline operated for the menopause, endometriosis and termination of pregnancy services. To enable monitoring of its effectiveness.
- The service should continue to implement an audit of patient clinical outcomes in the menopause service.
- The service should ensure all women and their families are included in all aspects of their care and treatment and given the opportunity to ask questions about their care and treatment.
- The service should consider adapting the same poster that is displayed on ward 8 for translation services in other clinical areas. This poster was written in different languages and not just in English as seen in other clinical areas.
- The service should consider updating policies related to Braille availability and increasing awareness of the availability of Braille amongst staff.
- The service should continue to review all services' outpatient clinics, to include pre-assessment, against the increased demand to ensure there are enough clinics and staff to run the service in a safe, effective and responsive manner.
- The service should develop formal service level agreements for the informal arrangements already in place, to ensure services are sustainable and all parties are committed and held accountable.
- The service should continue data cleansing to ensure all centralised information held by the trust is an accurate reflection of the services provided. To ensure assurance at trust level is accurate.

Neonatal Services at Birmingham Women's Hospital

- The service should ensure all staff consistently complete mandatory training in a timely manner.
- The service should ensure that wards rounds are consistently completed in a manner that promotes the privacy of neonates and their parents.
- The service should ensure that staff are aware of the arrangements in place to ensure the psychological needs of parents are met in the absence of a psychologist.
- The service should ensure that a formal neonatal strategy is developed in line with the trust's vision.

Diagnostic Imaging at Birmingham Women's Hospital

- The service should review fire safety training for all staff.

Summary of findings

- The service should provide training opportunities for staff that are offered frequently and accessibly.
- The service should review the location of resuscitation equipment in radiology/scan and ensure staff have a consistent understanding of maintenance and access.
- The service should establish annual screening for lead coats.
- The service should act on incident themes to ensure documentation and referral processes are stabilised, consistent and fit for purpose.
- The service should establish systems that ensure staff from multidisciplinary teams have the resources needed to collaborate and share learning, including when services lie in different directorates or departments.
- The service should implement quality assurance processes that ensure full compliance with the Ionising Radiation (Medical Exposure) Regulations (2017) (IR(ME)R).
- The service should display information about the trust complaints policy in patient areas in radiology/scan.
- The service should establish a schedule of meetings for all staff.
- The service should review the lone-working policy to ensure it is fit for purpose and provides appropriate support to staff.
- The service should establish communication with site leads out of hours to ensure staff leading clinics have support when needed from the senior team.

Community Maternity Services at Birmingham Women's Hospital

- The service should ensure all teams to have regular staff meetings producing minutes of the meetings.
- The service should ensure there is consistency in staff appraisals by all teams, diarising when they are due.
- The service should engage in local audits and measure their performance from them.
- Leadership visibility, input, and support should be consistent across teams within the service.
- The service should ensure all mandatory training is completed in line with Trust targets.

Mental Health Crisis Services and Health Based Place of Safety (Forward Thinking Birmingham)

- The service should ensure that staff are clear about how to manage issues relating to medicines management including the disposal of controlled drugs, signage for oxygen cylinders, and archiving of prescription charts.
- The service should ensure that staff in the health-based place of safety are able to identify whether the fire alarm has been activated in the suite so that appropriate action can be taken.
- The service should ensure all staff have access to and receive training in the Mental Health Act.

Community-Based Mental Health Services of Adults of Working Age (Early Intervention Psychosis Team, Forward Thinking Birmingham)

- The service should monitor clinical supervision to collect data and ensure that clinical supervision is occurring consistently for all staff across all services.
- The service should continue to undertake work to reduce caseload numbers to ensure they come in line with national guidance which states that staff should not have caseload numbers higher than 15.

Specialist Community Mental Health Services for Children and Young People (Forward Thinking Birmingham)

Summary of findings

- The service should ensure staff complete mandatory training in a timely manner, including training in the Mental Capacity Act 2005 and Mental Health Act 1983 (amended 2007).
- The service should ensure they respond to all forms of concerns and complaints, in line with their own policy.
- The service should ensure the recruitment process is managed in a timelier way, reducing unnecessary delays for staff coming into post and reducing the unnecessary burden placed upon existing staff.
- The service should ensure they continue to improve agile working facilities.
- The service should ensure they effectively identify and deal with diversity challenges within the service.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as good because:

- Leaders had the integrity, 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.
- The trust 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.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust provided opportunities for career development. The trust had an open culture where children, young people, women their families and staff could raise concerns without fear and be involved in all aspects of care.
- Leaders operated effective governance processes, throughout the trust and with partner organisations. 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.
- Leaders and teams used 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- 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.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research and strived to be influences on improved patient outcomes.

Ratings tables

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	Good	Outstanding	Good	Good	Good
Oct 2019	Oct 2019	Oct 2019	Oct 2019	Oct 2019	Oct 2019

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	Good ↑ Oct 2019	Outstanding ↔ Oct 2019	Outstanding ↔ Oct 2019	Outstanding ↔ Oct 2019	Good ↔ Oct 2019	Outstanding ↔ Oct 2019
Birmingham Women's Hospital	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Forward Thinking Birmingham	Good ↑↑ Oct 2019	Requires improvement ↔ Oct 2019	Good ↑ Oct 2019	Requires improvement ↑ Oct 2019	Good ↑↑ Oct 2019	Requires improvement ↑ Oct 2019
Overall trust	Requires improvement Oct 2019	Good Oct 2019	Outstanding Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019

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.

Ratings for Birmingham Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Medical care (including older people's care)	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Surgery	Good ↑ Oct 2019	Good ↓ Oct 2019	Outstanding ↑ Oct 2019	Good ↔ Oct 2019	Good ↔ Oct 2019	Good ↔ Oct 2019
Critical care	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Transition services	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	N/A	Outstanding Feb 2017	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017
Overall*	Good ↑ Oct 2019	Outstanding ↔ Oct 2019	Outstanding ↔ Oct 2019	Outstanding ↔ Oct 2019	Good ↔ Oct 2019	Outstanding ↔ Oct 2019

*Overall ratings for this hospital 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.

Ratings for Birmingham Women's Hospital

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

*Overall ratings for this hospital 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.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Community-based mental health services for adults of working age	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019
Mental health crisis services and health-based places of safety	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Specialist community mental health services for children and young people	Requires improvement ↑ Oct 2019	Requires improvement →← Oct 2019	Good ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019
Overall	Good ↑↑ Oct 2019	Requires improvement →← Oct 2019	Good ↑ Oct 2019	Requires improvement ↑ Oct 2019	Good ↑↑ Oct 2019	Requires improvement ↑ Oct 2019

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.

Acute health services

Background to acute health services

The trust provides a number of acute services across Birmingham Women's and Children's Hospital NHS Foundation Trust.

We inspected all acute services at Birmingham Women's Hospital which included:

- Gynaecology
- Neonates
- Maternity inpatient services
- Community maternity services
- Diagnostic imaging

At Birmingham Children's Hospital we inspected:

- Surgery

The services we did not inspect at Birmingham Children's Hospital included:

- Urgent and Emergency
- Medical Care
- Critical Care
- End of Life
- Transition services
- Outpatients
- Diagnostic imaging

Summary of acute services

Requires improvement

Our overall rating for the services provided by the trust was Require Improvement. Details of the findings from this inspection can be found in the main summary report.

Birmingham Women's Hospital

Mindelsohn Way
Birmingham
West Midlands
B15 2TG
Tel: 0121 472 1377
www.bwc.nhs.uk

Key facts and figures

Birmingham Women's Hospital is one of only two dedicated women's hospitals in the UK. The hospital provides specialist services to more than 50,000 women, men and their families every year from Birmingham, the wider region and beyond.

The hospital offers a full range of gynaecological, maternity and neonatal care. The hospital also offers fertility and fetal medicine services. The fetal medicine centre receives regional and national referrals and is home to the West Midlands Regional Genetics Laboratory.

(Source: Trust website)

Summary of services at Birmingham Women's Hospital

Good 

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated it them as good because:

- Our rating for safe was requires improvement overall. The service provided mandatory training in key skills however this was not accurately recorded on the electronic system which meant staff were reliant on their local records to monitor compliance. Some elements of the mandatory training for maternity staff were not included on the electronic system, and compliance rates were skewed by including staff who were off sick or on maternity leave. This meant it was difficult to get a clear picture of compliance rates for all maternity staff for all required training. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Our rating for effective was good overall. The service provided care and treatment based on national guidance and evidence of its effectiveness. Staff gave neonates enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. All those responsible for delivering care worked together as a team to benefit women.

Summary of findings

- Our rating for caring was good overall. Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided appropriate help and support for women before and after a termination of pregnancy or miscarriage. We observed staff involve patients and those close to them in decisions about their care and treatment during our inspection.
- Our rating for responsive was good overall. The trust planned and provided services in a way that met the needs of local people. Staff within the service took account of women's individual needs. They identified when women's needs and choices were not being met, and used information to inform how services were improved and developed.
- Our rating for well-led was good overall. Managers had the right skills and abilities to run a service providing high-quality sustainable care. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Although Radiology managers at all levels did not have the right skills and abilities to run imaging services and provide high-quality sustainable care. Local leaders in the medicine clinical group, which included radiology, were not aware of all the risks and challenges in the service.

Maternity Inpatients

Good 

Key facts and figures

The maternity directorate at Birmingham Women's and Children's NHS Foundation Trust provides a large and busy maternity service at Birmingham Women's Hospital where it delivers approximately 8,000 babies per year. Services include:

- A 23-bed delivery suite, consisting of a co-located midwife-led birthing centre, consultant led labour ward, induction of labour ward, maternal high dependency unit and two operating theatres.
- 75 antenatal and postnatal beds in three wards.

Outpatient services at the Women's Hospital for maternity include:

- Antenatal clinics, including specialist clinics to manage diabetes, endocrine disease, cardiology, perinatal mental health, haematology, renal disease, rheumatology, epilepsy, drug and alcohol issues, teenage pregnancy and HIV. These clinics are run jointly with the physicians from a neighbouring NHS trust, providing expert joint care for women with medical disorders in pregnancy.
- A supra-regional fetal medicine centre working closely with the trust's antenatal screening and genetics departments, and Birmingham Children's Hospital providing care to women and families from the West Midlands, across the UK and abroad.
- Physiotherapy services for gynaecology and maternity patients.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We visited the service on 9, 10 and 11 April 2019. We inspected the antenatal clinic, delivery suite, birth centre, day assessment unit, induction of labour suite, obstetric waiting lounge, the antenatal and postnatal wards and the fetal medicine department.

We observed care and spoke with 48 members of staff at different levels of seniority and from different disciplines. We spoke with 13 patients and four partners about their experience and care. We observed two handovers and attended a meeting with the service leads. We looked at 14 patient records including risk assessments, modified early obstetric warning scores and four medicine records.

Summary of this service

We rated this service as good because:

- There were clearly defined and embedded systems and processes to keep people safe and safeguarded from abuse, using local safeguarding procedures when necessary. Staffing levels and skill mix were planned, implemented and reviewed and staff shortages were responded to adequately. Staff could access the information they needed to assess, plan and deliver care, treatment and support to people in a timely way. Staff understand and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- People's care and treatment was planned and delivered in line with current evidence-based guidance and monitored to ensure consistency of practice. Women had comprehensive assessments of their needs and appropriate referral

Maternity Inpatients

pathways were in place to make sure these were addressed. Information about patients' care and treatment, and their outcomes, was routinely collected and monitored. There was participation in relevant local and national clinical audits. Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Women received coordinated care from a range of different staff, teams or services.

- Women were supported, treated with dignity and respect, and were involved as partners in their care. Staff supported people and those close to them to manage their emotional response to their care and treatment. Staff communicated with people and provided information in a way that they could understand. People understood their condition and their care, treatment and advice.
- People's needs were met through the way services are organised and delivered. Care and treatment were coordinated with other services and providers. Women could access the right care at the right time. Access to care was managed to take account of people's needs, including those with urgent needs.
- Leaders at every level were visible and approachable. The service was working with the local maternity system towards a statement of vision and values developed in collaboration with people who used the service, staff and, external partners. There were processes in place to support staff and promote their positive wellbeing. The board and committee levels of governance in the organisation functioned effectively and interacted with each other appropriately.
- There was a focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. There were organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems, and ways of sharing improvement work.

However:

- Mandatory training was not accurately or fully recorded on the electronic system which meant it was difficult to get a clear picture of compliance rates for all maternity staff for all required training. We did not see evidence of up to date monitoring or auditing for environmental infection prevention and control processes. The grading of incidents was unclear and not defined in the incident reporting policy.
- There appeared to be a low response rate for the friends and family test in some areas, for example in the antenatal clinic. Patients we spoke with had not been given surveys to complete and were not aware of the friends and family test.

Is the service safe?

Good 

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated safe as good because:

- The service provided mandatory training in key skills to all staff and was taking steps to make sure everyone completed it. The practical obstetric multi-professional training (PROMPT) included multidisciplinary scenario training and the service provided information showing good compliance with attendance by maternity staff.

Maternity Inpatients

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training specific to their role on how to recognise and report abuse and during the inspection they provided examples to us of when they had done so.
- Most clinical areas were clean and had suitable furnishings which were well-maintained. Staff used control measures to prevent the spread of infection including the use of personal protective equipment. The service had enough suitable equipment to help them to safely care for women and babies and suitable facilities to meet the needs of patients' families.
- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed risk assessments for each woman on admission or arrival and updated them when necessary. Alerts on the electronic system provided prompts to staff where risks had been identified. They kept clear records and asked for support when necessary. We saw that early warning score tools were in use and completed for mothers and babies. The delivery suite had provision for women requiring high dependency care and there was a high dependency midwife in post.
- The service was working actively to monitor and maintain the right levels of midwifery and medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Workforce reviews were undertaken regularly, and we saw evidence that these were discussed at operational, local level and trust board level meetings. Where there were shortfalls, these were managed appropriately, and red flag staffing incidents were submitted when the relevant criteria were met.
- Staff kept appropriate records of women's care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Patients received the right medication at the right dose at the right time. There were some environmental concerns related to the temperature in rooms and fridges where medicines were being stored and the trust was working to address these.
- Staff recognised and reported incidents. Clinical areas had midwives with protected time to lead incident investigations and share any learning. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Evidence provided after inspection included some examples of quarterly governance bulletins with highlights of lessons learned from incidents and audits
- Staff collected safety information and a performance dashboard had been developed with plans in place to use this to improve the service.

However:

- The service provided mandatory training in key skills however this was not accurately recorded on the electronic system which meant staff were reliant on their local records to monitor compliance. Some elements of the mandatory training for maternity staff were not included on the electronic system, and compliance rates were skewed by including staff who were off sick or on maternity leave. This meant it was difficult to get a clear picture of compliance rates for all maternity staff for all required training.
- Following inspection, we received some evidence of up to date monitoring and auditing for environmental infection prevention and control processes including hand hygiene or bare below the elbow however actions had not been completed where results were below target. Some areas we visited had equipment that was not cleaned to the required standard. Staff we spoke with were unclear how often disposable curtains should be changed and the policy did not specify.

Maternity Inpatients

- Post Caesarean section wound infections had been identified as a risk following a cluster of incidents but the rate and number of surgical site infections was omitted from the action plan so it was unclear how improvements would be monitored and measured. The grading of incidents was unclear and not defined in the incident reporting policy.

Is the service effective?

Good 

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. A clinical audit programme was in place which included participation in national and local audits to support and monitor implementation of national guidance and best practice. There was a committee structure in place to lead this.
- New mothers were supported in feeding their baby as they chose and there was an infant feeding team on the postnatal wards to help with this. Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. Women we spoke with on the antenatal ward told us they had discussed all options for pain relief in labour. Aromatherapy was available to certain women to help them relax and birthing pools were in use in the birth centre and on the delivery suite.
- Staff monitored the effectiveness of care and treatment and used the findings to make improvements. The service had been accredited under Baby Friendly initiative, set up by UNICEF and the world health organisation. They compared local results with those of other services to learn from them. A performance dashboard had been developed in response to findings from the national audit. Work was ongoing to improve the quality of data submissions.
- The service made sure staff were competent for their roles. Specialist competency training was in place for midwives on the high dependency unit and a comprehensive preceptorship was in place for newly qualified midwives. A rotation system was in place which enabled midwives to work in different clinical areas to maintain their skillset.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, midwives and other healthcare professionals supported each other to provide good care. Combined clinics with input from midwives and obstetricians were in place, and physicians from a neighbouring trust provided expertise in specialist areas such as rheumatology and epilepsy.
- Maternity services were available seven days a week to support timely care. Staffing was planned to accommodate this and reception areas were manned 24 hours a day.
- Staff gave women practical support and advice to lead healthier lives. Information leaflets were widely available in all areas we visited. These included information about postnatal support, infant feeding and cot death. There was advice on smoking, sleep safety and healthy eating.
- Staff were knowledgeable about the need for informed consent for invasive procedures. This was recorded appropriately in the patient notes we reviewed.

However:

Maternity Inpatients

- Data submitted to the national audits was not always robust. A review of data quality and possible contributing factors was underway and due for completion in October 2019.

Is the service caring?

Good ●

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated caring as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from patients confirmed that staff treated them well and with kindness. Friends and family results were displayed on the noticeboard in the antenatal clinic. We observed staff showing women kindness and support when interacting with them.
- Staff provided emotional support to patients to minimise their distress. Counselling was offered by the fetal medicine team where distressing complications in pregnancy had been identified and there was a bereavement suite on the delivery unit for parents whose baby had died.
- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment. We observed good interaction with patients in the different clinical areas. Staff listened to the mothers, provided information and explained what was happening.

However:

- Although we saw evidence that responses to the friends and family test were positive there appeared to be a low response rate in some areas, for example in the antenatal clinic. Patients we spoke with had not been given surveys to complete and were not aware of the friends and family test.

Is the service responsive?

Good ●

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated responsive as good because:

- The trust planned and provided services in a way that met the needs of local people. There was a wide range of specialist services supported by specialist midwives and specialist clinicians including some from a neighbouring NHS trust.
- We visited the regional consultant-led fetal medicine centre which offered specialist care for the unborn baby to women with complex pregnancies from the West Midlands region and a supra-regional service across the United Kingdom.

Maternity Inpatients

- The service took account of patients' individual needs. Translators and interpretation services were available and alerts on the patient electronic record flagged up where patients may require extra support or a particular risk had been identified.
- People could access the service when they needed it. Capacity within the maternity service had been reviewed and booking systems had been adjusted to more accurately reflect demand for births at the hospital. This meant that the service was now able to accept all women referred for care.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good 

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated well-led as good because:

- Managers had the right skills and abilities to run a service providing high-quality sustainable care. There was a new head of midwifery in post and professional midwifery advocates had been appointed to provide supervision and support to midwives in the service.
- The service was working within a local maternity system to develop a vision for what it wanted to achieve with workable plans to turn it into action. There was involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There were systems and processes in place which facilitated the sharing of governance reports with the appropriate committees up to trust board level.
- The service had effective systems for identifying risks and planning to eliminate or reduce them. A local risk register was in place and we saw evidence of discussion about workforce issues and future planning at local and trust level meetings.
- The trust collected, analysed, managed and used information well to support some of its activities, using secure systems with security safeguards. The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Work was ongoing to improve access to the single electronic patient records developed within the local maternity system.
- The service was proactive in engaging with staff and patients. Initiatives were in place to communicate with staff who could not always leave their clinical duties to attend meetings. Staff survey results were reviewed by managers and actions were in place to improve the working environment. Women were invited to be involved with the maternity service and there were posters on display in the hospital and public information on the internet providing details of how they could do this.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Maternity Inpatients

However:

- We did not see evidence of regular discussion about individual incidents, case reviews or incident trends at a local operational level.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Key facts and figures

Birmingham Women's Hospital was acquired by Birmingham Children's Hospital in February 2017 and became part of a new legal entity, the Birmingham Women's and Children's Hospitals NHS Foundation Trust. Gynaecology services at the trust are provided at Birmingham Women's Hospital for women and their families.

Gynaecology is an integrated service including assessment, diagnosis and treatment of women's disorders and diseases.

Inpatient services include:

- Operating theatres for elective and emergency gynaecology and obstetrics
- Two inpatient wards
- Dedicated abortion care service for complex termination of pregnancy
- Obstetric Anal Sphincter Injuries (OASIS) service, providing specialist follow up to women with significant perineal trauma following birth.

Outpatient services at the Women's Hospital for gynaecology include:

- Hysteroscopy suite offering outpatient diagnostic and therapeutic hysteroscopy including sterilisation. Hysteroscopy is a procedure used to see inside the womb using a hysteroscope, which is a narrow telescope with a light and camera at the end. The procedure is used to investigate symptoms or problems such as heavy periods, diagnose conditions such as non-cancerous growths in the womb (fibroids and polyps) and to treat conditions such as removal of fibroids and polyps.
- Colposcopy suite offering outpatient procedures to monitor or treat women with abnormal cervical smear results. Colposcopy is a procedure used to look at the cervix, the lower part of the womb at the top of the vagina. Women are referred for this procedure when their cervical smear results show abnormal cells. The procedure can be used to diagnose abnormal cells, take a small sample of tissue (biopsy) or treatment to remove abnormal cells.
- Urogynaecology Unit offering video, laboratory and ambulatory urodynamics. Urogynaecology is a sub-speciality of urology (the study of urinary-tract systems) and gynaecology (the study of female reproductive systems). The speciality provides care and treatment for problems related with abnormal or impaired pelvic floor muscles and the bladder.
- Outpatient cystoscopy service. Cystoscopy is a procedure that looks inside the bladder using a thin camera called a cystoscope. It is used to diagnose and treat problems with the urethra (small tube that connects to the bladder and allows the removal of urine from the body) and the bladder.
- General gynaecology outpatients including the longest established Menopause clinic in the UK. Menopause is a natural part of ageing where a women's oestrogen (primary female sex hormone) levels reduce.
- Specialist pain/endometriosis clinics. Endometriosis is an often painful condition where by the tissue (endometrium) which usually lines the inside of the womb (uterus) grows outside the womb.
- Oncology services at unit level to include management of pre-invasive disease of the genital tract through rapid referral two-week clinics.

Gynaecology

- A hyperemesis daycentre and outpatient management of miscarriage service is also provided in the early pregnancy assessment unit (EPAU) which is available seven days a week. Hyperemesis gravidarum is a condition during pregnancy that is characterised as severe nausea and vomiting, weight loss and dehydration.
- Nurse led Pre-Assessment clinics.
- Physiotherapy services for gynaecology and maternity patients.
- Centre for complex endometriosis.

The trust offers both medical and surgical terminations of pregnancy at the Women's Hospital. As part of the termination of pregnancy (ToP) service there is counselling given at a patient's appointment. As a subset the trust also offer bereavement counselling to all pre- and post-ToP (medical or surgical) and any ToPs with signs of life is followed up by bereavement services.

(Source: RPIR acute context tab)

The termination of pregnancy service offers outpatient appointments on Monday, Wednesday and Fridays. Most referrals are made to the service from the independent healthcare specialist termination of pregnancy providers.

Activity:

From January 2018 to December 2018 the gynaecology service saw the following activity:

- Inpatient spells* - 4,084
- Inpatient activity – 4,108
- Inpatient elective – 1,630
- Inpatient emergency – 1,333
- Inpatient day case – 1,145
- Outpatient activity – 66,997
- Outpatient follow up – 35,122
- Outpatient new – 31,875

* An inpatient spell is the total continuous stay of a patient using a hospital bed, where the medical care is provided by one or more consultants, or the patient is receiving care under one or more nursing episodes on a ward.

(Source: RPIR P77 Dashboards – BW activity scorecard tab)

The termination of pregnancy service undertook more than 600 complex care abortions during 2018/19. This increased from approximately 270 a year in 2016/17. The service provides medical and surgical terminations of pregnancy up to 19 weeks and 6 days gestation.

Birmingham Women's Hospital was last inspected in April 2016, before they were acquired by Birmingham Children's Hospital and became a new legal entity in February 2017.

We inspected all five key questions of the gynaecology service because it had not been inspected since the acquisition.

We inspected the following areas during our visit:

Gynaecology

- Ward 7, which is an overflow gynaecology ward for women receiving gynaecological procedures or treatment, including termination of pregnancy. This ward is generally used for women receiving a day case procedure. It has 16 beds in the form of two six bedded bays and three side rooms (two single and one double).
- Ward 8, which is a gynaecology ward for women receiving gynaecological procedures or treatment, including termination of pregnancy. It has 24 beds in the form of three six bedded bays and four side rooms (two double and two single).
- Outpatient's department, which is where all gynaecology clinics including the menopause service, endometriosis service, oncology clinics and termination of pregnancy clinics are provided. It has five consultation and treatment rooms.
- Gynaecology theatres, which are dedicated theatres for gynaecological surgeries. There are two dedicated theatres for the gynaecology service.
- Hyperemesis day centre, which is located on the EPAU. Staff treat women with rapid fluid and medication infusion through intravenous access on a day case basis. It has one room with two comfortable chairs for treating women.
- Hysteroscopy and colposcopy suite, which has one treatment room for hysteroscopy and two treatment rooms for colposcopy.
- Urogynaecology and urodynamics unit, which has five consultation rooms and one treatment room.
- Pre-assessment unit, which is where women go to be assessed one or more days before they are due for a surgical procedure. The clinic appointment is where nurses check if women have any medical problems that might need to be treated before their operation, or if they will need special care during or after the surgery. It has four consultation rooms and two clinic rooms.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- Spoke with nine women who were using the service and a family member.
- Spoke with the divisional manager, clinical lead and head of nursing for gynaecology services.
- Spoke with the safeguarding team manager and safeguarding adult's nurse lead for Birmingham Women's Hospital.
- Spoke with the deputy clinical lead for gynaecology and the lead for termination of pregnancy services.
- Spoke with 14 other staff members; including doctors, nurses and health care assistants.
- Observed a ward round, a safety huddle and two clinics.
- Reviewed cleaning schedules and documented safety processes.
- Reviewed 23 patient records relating to physical health, risk assessments and care plans.
- Four of the records reviewed were focussed around mental capacity assessments and best interest decisions.
- Ten of the records were specifically around termination of pregnancy.

Gynaecology

Summary of this service

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated it as good because:

- Safeguarding adults, children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification.
- Women who used services had good outcomes because they received care and treatment that met their needs.
- Women who used services were supported, treated with dignity and respect, and were mostly involved as partners in their care.
- Most women's individual needs were met through the way services were organised and delivered.
- The local leadership, governance and culture promoted the delivery of high-quality, person-centred care.
- There were good safety process, systems and procedures to keep people safe. This included infection, prevention and control, servicing and maintenance of equipment, and storage of medicines and intravenous fluids.
- Staff competency within the termination of pregnancy service were good. Staff were trained and had professional development in the management of physical and emotional aspects of late terminations.
- The perception of the priority given to gynaecology services within the wider trust was equal to maternity services. Developments and improvements to the service and addressing risk was carried out in a timely manner.

However;

- Women were not always protected from avoidable harm. Systems, processes and procedures were not always consistently implemented across the service.

Is the service safe?

Requires improvement

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated it as requires improvement because:

- The trust did not always provide mandatory training in key skills and safeguarding training to all staff. Data showed nursing and medical staff compliance rates were consistently low and not meeting trust targets.
- The design, maintenance and use of facilities and premises in some areas did not always keep people safe. Staff did not always manage clinical specimens well.
- All services within the gynaecology department had seen an increase in demand and staff were concerned the staffing levels were no longer reflecting demand. We did not have the confidence or assurance that the information provided by the trust on staffing was accurate.

Gynaecology

- There was inconsistent direct access to a named consultant for doctors in training, particularly when consultants were on annual leave.
- Staff did not always write individual care records in a way that kept women safe. Handwriting was unreadable at times and there were inconsistencies in consultants dating and timing entries and including general medical council numbers.
- Patient information was not always kept confidential. There were incidents where confidential information was misplaced in other women's records.
- The service did not use safety thermometer monitoring data well.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There were clearly defined systems, processes and practices to protect people from abuse, which included those at risk of suicide or self-harm, and domestic violence. Staff knew their roles and responsibilities and followed safeguarding policies and procedures.
- Most staff had received training to make them aware of the potential needs of people with mental health conditions, learning disabilities and dementia.
- Staff understood their role in reporting Female Genital Mutilation (FGM) and had an awareness of Child Sexual Exploitation (CSE) and understood the law to detect and prevent maltreatment of children.
- Local managers monitored mandatory training compliance and had action plans to improve compliance rates. Staff had the opportunity to discuss their progress towards mandatory compliance targets and any concerns or issues with completing or accessing their training.
- Staff within the service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. There were reliable systems in place to prevent and protect people from a healthcare-associated infection that were in line with national guidance.
- Equipment was available, fit for purpose and conformed to the relevant safety standards and were regularly serviced. They were stored, checked and tested in line with professional guidance.
- Staff completed and updated risk assessments for each woman using the service. They kept clear records and asked for support when necessary. Risk assessments were comprehensive and followed risk management plans developed in line with national guidance.
- Staff identified and responded appropriately to changing risks for women who used the service. This included continuation of monitoring and treating women identified as having sepsis.
- The service had enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment. Senior staff planned and reviewed staffing levels and skill mix, so that women received safe care and treatment at all times.
- Staff within the service followed best practice when prescribing, giving, recording and storing medicines. Women received the right medication at the right dose at the right time.
- Staff kept detailed records of patients' care and treatment. Records were up-to-date and easily available to all staff providing care. Women's records were organised, easy to follow and showed evidence of a multi-disciplinary approach to care.
- The termination of pregnancy service had processes to ensure compliance with the Abortion Act 1967. Staff completed legal forms (HSA1 and HSA4) required under the Act appropriately.

Gynaecology

- Staff within the service followed best practice when prescribing medicines. Staff managed and stored medicines and medicines related stationery appropriately. Senior staff reviewed practices regularly through medicines management audits.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good ●

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Guidelines and policies were based on current evidence-based guidance outlined by the National Institute for Health and Care Excellence (NICE) and professional bodies of gynaecology and its subspecialties.
- Many of the sub-speciality services provided were accredited by professional bodies and had contributed to the development of national standards. The services ensured compliance with professional standards to maintain accreditation.
- Staff gave women enough food and drink to meet their needs and improve their health. They used special hydration techniques when necessary. Staff made adjustments for women's religious, cultural and other preferences.
- Staff assessed and monitored women regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Senior staff within 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 monitor the effectiveness of the service.
- There were several clinical nurse specialists throughout the service. This included specially trained staff to provide emotional support for women who had undergone termination of pregnancy, miscarriage or ectopic pregnancy (where the egg implants outside the womb, commonly in a fallopian tube).
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- The service was meeting the NHS England's seven-day services priority standards. There was sufficient pharmacy cover and availability that included weekends and Bank Holidays.

Gynaecology

- Staff provided health information to support women in monitoring and improving their health and wellbeing. They worked well with the wider local health economy to increase a better understanding of health promotion and management of diseases. Staff engaged with patient groups to promote services and remove stigma around screening for gynaecological cancers.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.

However:

- At the time of our visit, staff were in the process of reviewing clinical key performance indicators for gynaecology and its subspecialties. There were no clinical key performance indicators being reported to the board whilst these were being reviewed.
- There were no key performance indicators for the 24-hour a day, seven days a week helpline provided for menopause, endometriosis and termination of pregnancy services. Staff did not monitor how quickly they were calling women back after the women had left voicemails.
- Staff in some areas were behind with their appraisals and professional development reviews due to staff sickness.

Is the service caring?

Good ●

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated it as good because:

- Staff cared for patients with compassion. They took the time to interact with women who used services and those close to them in a respectful and considerate way.
- Staff provided appropriate help and support for women before and after a termination of pregnancy or miscarriage. They adopted a non-directive, non-judgemental and supportive approach for women receiving a termination of pregnancy. Staff referred to pregnancy remains from miscarriage or termination in line with how the family referred to them.
- Feedback from patients confirmed that staff treated them well and with kindness. Staff assessed a woman's experience of outpatient and inpatient gynaecology services through adapted friends and family test questionnaires developed specifically for each area.
- Staff provided emotional support to patients to minimise their distress. They gave women appropriate and timely support and information to cope emotionally with their care, treatment or condition. Staff advised women on how to find other support services when necessary.
- Staff promoted ways to maintain the privacy and dignity of women when undergoing examinations.
- Staff communicated with women in a way that they understood their care, treatment and condition. Most staff involved women who used services and those close to them in planning and making shared decisions about their care and treatment. Most staff listened to, respected and considered women's feelings.

However:

Gynaecology

- Staff did not always involve patients and those close to them in decisions about their care and treatment. Not all women and their loved ones knew what was happening with their care or had opportunities to ask questions. There was an isolated incident where a woman did not feel staff considered her feelings about treatment.
- Staff did not always ensure women were given the opportunity of making an informed choice about all available termination of pregnancy methods that were appropriate and safe for their clinical need and risk.

Is the service responsive?

Good 

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. Services provided mostly reflected the needs of the population served and aimed to provide flexibility, choice and continuity of care.
- Staff within the service took account of women's individual needs. They identified when women's needs and choices were not being met, and used information to inform how services were improved and developed.
- Staff delivered and coordinated services to ensure they were accessible and responsive to women with complex needs. Key staff worked across services to coordinate women's involvement with families and carers, particularly for women with complex needs.
- Staff made reasonable adjustments so women with a disability could access and use services on an equal basis to others.
- There were arrangements for delivering the service to take account of the needs of different women, for example those needing translation services. The provider partially complied with the Accessible Information standard by identifying, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss.
- Women could mostly access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with good practice.
- Women with the most urgent needs had their care and treatment prioritised.
- Clinics generally ran on time and women were made aware of any delays or disruptions.
- The hospital's surgical and medical services were dedicated to gynaecology. There was a dedicated gynaecology and a dedicated termination of pregnancy service.
- There were clear criteria for referral to the termination of pregnancy service.
- Oncology referral to treatment times consistently met the national standards and were higher than the England average.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Women who used services knew how to make a complaint or raise concerns.
- Staff were proud of the number of compliments and positive feedback they received from women who used services

Gynaecology

However:

- There was no commissioning for counselling or contraception services within the termination of pregnancy service. This meant the trust had to fund counselling services.
- Translation services posters were only displayed in English in most of the clinical areas.
- Staff were unclear on how to arrange braille for women with sight impairments, or whether it was available to request. We saw an isolated incident where a woman with a sight impairment did not have her needs met in respect of their understanding of information.
- The termination of pregnancy service could not ensure that women were offered a termination of pregnancy appointment within five working days of referral.

Is the service well-led?

Good 

The Birmingham Women's Hospital became part of The Birmingham Women's and Children's Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated it as good because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. They understood the challenges to quality and sustainability, and identified the actions needed to address them.
- Senior staff within the service were in the process of drafting a vision for what it wanted to achieve and workable plans to turn it into action. This was being developed with involvement from staff, patients, and key groups representing the local community. Staff within subspecialties had a vision for their specialist services.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a strong emphasis on the safety and wellbeing of staff.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- There were mostly effective structures, processes and systems of accountability to support the delivery of strategies and good quality services at a local level. The local level of governance and management functioned effectively and interacted with each other appropriately. Staff at all levels within the service were clear about their roles and understood what they were accountable for, and to whom.
- Arrangements with partners and third-party providers encouraged appropriate interaction and promoted coordination and person-centred care.
- Policies, procedures and guidance for staff were based on evidence-based practice, national standards and legislation.
- The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. These were comprehensive and clear. Escalation of performance issues and actions taken to address them were appropriate.

Gynaecology

- Risk registers were detailed and clearly documented responsible individuals. The risk registers linked to the board assurance framework when concerns were identified. Leaders were able to articulate assurance processes and gave examples of risks that had been identified and escalated.
- The service collected, analysed, managed and used information to support activities, using secure electronic systems with security safeguards.
- Staff ensured they maintained women's confidentiality through the management of information.
- There were effective processes for ensuring external notifications were submitted to external bodies in line with legislation. This included compliance with requirements of the Abortion Act 1967 and Regulations for Submission of HSA4 forms to the Department of Health's Chief Medical Officer.
- Routine data collections were used to monitor and improve performance issues and to provide assurance to service leaders and the board.
- Staff within the service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- Staff within the service were committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. They regularly sought opportunities to be involved with continuous learning, improvement and innovation. This included participating in appropriate research projects and recognised accreditation schemes.

However:

- There was a disconnect between some local level governance and trust level governance systems.
- Not all service level agreements were governed and managed in a way that ensured sustainability.
- Some gynaecology specific and general policies were expired or due to expire soon after our inspection visit.
- The service was not always sighted on all potential risks when making changes to service environments.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Neonatal services

Good 

Key facts and figures

The Neonatal service at Birmingham Women's Hospital supervises the care of all babies born within the trust and is part of the Southern West Midlands New-born Network (SWMNN), delivering care to the sickest babies born in the region and beyond.

The service comprises the neonatal intensive care unit (NICU), a transitional care ward for mothers and babies, the hosted West Midlands new-born transfer service, and the regional donor Human Milk Bank.

The NICU team also works in partnership with the team at Birmingham Children's Hospital providing pre- and post-operative care for neonates with surgical conditions, and increasingly support for new-borns with cardiac conditions, with a sharing of staff expertise between the two locations.

(Source: Trust Provider Information Request – Community context)

During this inspection, we visited the NICU and transitional care ward as these services fell under the neonatal core service framework that we used in accordance with our inspection methodology. The neonatal transfer service was registered under the location of Birmingham Children's Hospital.

We spoke with five parents about their care experiences. We also spoke with 38 members of staff about the delivery of care and the management of the neonatal services. These 38 staff members consisted of; 15 nurses, four consultant neonatologists, two matrons, two health care support workers, a ward manager, the head of nursing for neonatal services, a nurse consultant, a clinical support worker, a consultant paediatrician, a team leader for palliative care, the deputy head of nursing, a physiotherapist, a radiographer, a discharge lead nurse, a pharmacist, the clinical director for neonatal care, a safeguarding nurse, and advanced neonatal nurse practitioner and a junior doctor.

We also reviewed eight sets of neonate records and four medicines administration records to check they were accurate and up to date and we observed two daily huddles and a staff handover.

This is the first inspection of neonatal care at this location since the formation of the new trust in February 2017.

Summary of this service

We rated the service as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each neonate. They kept clear records and asked for support when necessary.
- An effective early warning system was in place to identify deteriorating neonates and appropriate action was taken in response to this.

Neonatal services

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of neonates' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. Neonates received the right medication at the right dose at the right time.
- The service managed neonate safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave parents honest information and suitable support.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave neonates enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored neonates regularly to see if they were in pain and gave pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- 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 monitor the effectiveness of the service.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Arrangements were in place to ensure neonates could access medical support seven days a week.
- Parents were supported to manage their neonates' specialist care and wellbeing needs where appropriate to enable them to live healthier lives.
- Parental consent was sought in line with the Children's Act 1989 and 2004. Staff understood how and when to assess whether a parent had the capacity to make decisions about a neonates' care and followed current legislation, trust policy and procedures when a parent could not give consent.
- Staff cared for neonates and their families with compassion. Feedback from parents confirmed that staff treated them and their neonates well and with kindness.
- Staff provided emotional support to neonates and their families to minimise their distress.
- Staff involved parents in decisions about their neonates' care and treatment.
- The trust planned and provided services in a way that met the needs of local people.
- The service took account of the individual needs of neonates and their families.
- People could mostly access the service when they needed it. Arrangements to admit, treat and discharge neonates were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Managers at all levels had the right skills and abilities to run a service providing high quality sustainable care.

Neonatal services

- The service had a vision for what it wanted to achieve. However, a formal neonate strategy was not yet in place to outline how this vision could be attained.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with parents and staff to plan and manage appropriate services effectively.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

However:

- The trust's training compliance targets were not always met.
- Many policies and procedures relating to neonatal care had exceeded their review date which meant we could not be assured that policies and procedures were based on the most up to date areas of best practice.
- Ward rounds were not always completed in a manner that promoted privacy.
- Some staff were unaware of any formal arrangements to ensure the psychological needs of parents were met in the absence of a psychologist.

Is the service safe?

Good ●

We rated it as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each neonate. They kept clear records and asked for support when necessary.
- An effective early warning system was in place to identify deteriorating neonates and appropriate action was taken in response to this.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of neonates' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Neonatal services

- The service followed best practice when prescribing, giving, recording and storing medicines. Neonates received the right medication at the right dose at the right time.
- The service managed neonate safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave parents honest information and suitable support.

However:

- The trust's training compliance targets were not always met.

Is the service effective?

Good ●

We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave neonates enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored neonates regularly to see if they were in pain and gave pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- 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 monitor the effectiveness of the service.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Arrangements were in place to ensure neonates could access medical support seven days a week.
- Parents were supported to manage their neonates' specialist care and wellbeing needs where appropriate to enable them to live healthier lives.
- Parental consent was sought in line with the Children's Act 1989 and 2004. Staff understood how and when to assess whether a parent had the capacity to make decisions about a neonates' care and followed current legislation, trust policy and procedures when a parent could not give consent.

However:

- Many policies and procedures relating to neonatal care had exceeded their review date which meant we could not be assured that policies and procedures were based on the most up to date areas of best practice.

Is the service caring?

Good ●

We rated it as good because:

Neonatal services

- Staff cared for neonates and their families with compassion. Feedback from parents confirmed that staff treated them and their neonates well and with kindness.
- Staff provided emotional support to neonates and their families to minimise their distress.
- Staff involved parents in decisions about their neonates' care and treatment.
- Staff interacting with neonates and their families from a wide range of cultural and religious backgrounds using a consistent, caring approach.

However:

- Ward rounds were not always completed in a manner that promoted privacy.

Is the service responsive?

Good ●

We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- The service took account of the individual needs of neonates and their families.
- People could mostly access the service when they needed it. Arrangements to admit, treat and discharge neonates were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- Some staff were unaware of any formal arrangements to ensure the psychological needs of parents were met in the absence of a psychologist.

Is the service well-led?

Good ●

We rated it as good because:

- Managers at all levels had the right skills and abilities to run a service providing high quality sustainable care.
- The service had a vision for what it wanted to achieve. However, a formal neonate strategy was not yet in place to outline how this vision could be attained.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Neonatal services

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with parents and staff to plan and manage appropriate services effectively.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity (community services)

Good 

Key facts and figures

Maternity services provide professional and caring support to thousands of families each year. From the day they know about being pregnant, the services help families to choose how they want to have their baby and how they want to be cared for during and after pregnancy.

Maternity services offer women a series of antenatal appointments with a midwife, or sometimes an obstetrician, a doctor who specialises in pregnancy and birth.

The service comprises a team of experienced midwives, consultant obstetricians and healthcare professionals to help women through their pregnancy and child birth.

Women have a choice of where they would like to have their baby depending on their preference and specific needs. This can either be a home birth or delivery suite.

Women are given a Personal Child Health Record (PCHR) – sometimes referred to as the ‘red book’ - which is a record of the child’s growth, development and use of health services.

Community team of midwives provide postnatal care and support for women for a minimum of ten days after birth. This is usually delivered over a minimum of three contacts with community team depending on the needs before the women are referred to health visitors.

Community midwives provide the following:

- Weigh and carry out routine screening tests on your baby with your informed consent
- Check both you and your baby remain healthy
- Explain various choices to promote good health for both you and your baby
- Offer family planning advice

Summary of this service

The Birmingham Women’s Hospital became part of The Birmingham Women’s and Children’s Hospitals NHS Foundation Trust in February 2017. This meant our ratings from the last inspection of this hospital in 2016, no longer applied at the time of this 2019 inspection.

We rated it as good because:

- The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff monitored the effectiveness of care and treatment.
- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Maternity (community services)

- 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.
- Leaders had the integrity, 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 women and staff. They supported staff to develop their skills and take on more senior roles.

Is the service safe?

Good ●

We rated it as good because:

- The service provided mandatory training in key skills to all staff. However; the service did not make sure everyone completed it.
- Staff understood how to protect women from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well.
- The maintenance and use of equipment kept people safe.
- Staff completed and updated risk assessments for each woman and removed or minimised risks.
- The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of women's' care and treatment.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- The service used monitoring results well to improve safety.

Is the service effective?

Good ●

We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff regularly checked if women were eating and drinking enough to stay healthy and help with their recovery.
- Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles.
- All those responsible for delivering care worked together as a team to benefit women.
- Key services were available seven days a week to support timely care.
- Staff gave women and their families practical support and advice to lead healthier lives.

Maternity (community services)

- Staff supported women to make informed decisions about their care and treatment. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. However, the service did not ensure that all staff completed essential training in these subjects.

Is the service caring?

Good ●

We rated it as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to women, families and carers to minimise their distress.
- Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good ●

We rated it as good because:

- 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.
- The service was inclusive and took account of women's individual needs and preferences.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received.

Is the service well-led?

Good ●

We rated it as good because:

- Leaders had the integrity, 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 women and staff. They supported staff to develop their skills and take on more senior roles.
- 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.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There were systems and processes in place which facilitated the sharing of governance reports with the appropriate committees up to trust board level.

Maternity (community services)

- The service had effective systems for identifying risks and planning to eliminate or reduce them.
- The trust collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards.
- The service was proactive in engaging with staff and women and their families.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diagnostic imaging

Requires improvement 

Key facts and figures

Diagnostic imaging services at Birmingham Women's and Children's NHS Foundation trust are provided at Birmingham Women's Hospital and at Birmingham Children's Hospital. The senior leadership team is based cross-site and our report includes reference to this team. Some staff and services, including radiologists and MRI scans, are provided through service level agreements with an adjacent NHS hospital that is part of another trust. We refer to this trust in the report but our ratings only reflect the Birmingham Women's Hospital.

Diagnostic imaging is provided primarily in the dedicated radiology/scan department. This service has 13 ultrasound machines and offers ultrasound and x-rays for gynaecology, maternity and neonatal patients, including for developmental dysplasia of the hip. The department has one x-ray room for general, plain film x-rays and fluoroscopy. There are two mobile x-ray machines in the hospital, one stored in radiology and one used mainly in neonates. Ultrasound machines are also based in the early pregnancy assessment unit (EPAU), the antenatal clinic and the neonatal clinic.

Gynaecology ultrasound is the most frequent type of work carried out by radiologists, who also carry out around 100 adult x-rays per year.

In 2017 the hospital amalgamated with Birmingham Children's Hospital, which resulted in a reconfiguration of the divisional and leadership structures.

The service reported the following monthly range of activity rates between January 2019 and March 2019:

- Fluoroscopy: 80 – 120
- Plain film: 210 – 250
- Obstetrics: 4,200 – 4,600
- Non-obstetrics: 1,100 – 1,300

Between April 2018 and March 2019, 9,479 ultrasound scans took place in EPAU.

To come to our ratings, we spoke with 23 members of staff representing a range of roles and levels of seniority and spoke with seven patients. We observed eight patient consultations and reviewed five sets of patient's records. We spent time observing care in radiology/scan and in the EPAU. During our inspection we reviewed information available locally and asked the trust to provide further documentation afterwards. In total we took into account over 90 individual pieces of evidence. We carried out an unannounced out of hours inspection on a Saturday morning to understand how services worked when the hospital was quieter and there were fewer staff present.

The EPAU is part of the gynaecology department and is operationally and clinically separate from the radiology/scan department. The unit provides services other than diagnostic imaging and our report reflects only aspects of the service involved with imaging and scanning.

We have not previously inspected diagnostic imaging as an individual core service as part of this trust.

Summary of this service

We rated it as requires improvement because:

Diagnostic imaging

- There were significant gaps in safeguarding processes and practices that were not effectively overseen by the senior team or by the trust safeguarding team.
- Incident-reporting processes were inconsistent; staff did not always recognise incidents and learning was not always shared or identified.
- Staffing levels were insufficient to meet demand and there was limited evidence the trust had a robust strategy to address this.
- Local safety systems were not fully functioning and there were gaps in risk assessments, documentation of staff training and equipment servicing.
- There was very limited auditing or benchmarking for radiology services, which reflected inconsistent senior leadership and persistent short staffing.
- Although patients spoke positively about the care they received, communication from staff was not always clear and consistent.
- Radiologists provided an on-call service to help provide urgent care and reduce waiting times for reports. However, the trust had no oversight of this system, which was unofficial and tenuous. Radiologists provided clinical advice and guidance in their own personal time and whilst on duty at another NHS trust.
- Senior leadership in radiology was not functioning. There was no senior clinical oversight of the service, above the radiology professional manager level, and the divisional leadership team was entirely detached from the service. They had no awareness of the significant challenges the departmental team faced and rarely visited the department. During or weekend unannounced inspection, the most senior person in the hospital thought the department was closed and was unaware staff were running a full list. This was demonstrative of the lack of engagement between the trust and the department.

However, we also found areas of good practice:

- Most areas that required improvement related only to the radiology/scan department. The early pregnancy assessment unit (EPAU) had more robust safety and governance systems in place.
- Staff in the EPAU had developed extensive local practices for safeguarding that had resulted in improved safety for a number of patients not previously known to be at risk.
- The EPAU team had developed a range of communication tools to help deliver more effective care for patients living with a learning disability.
- Staff engaged well with patients and there was evidence they were able to shape the service and its development.
- The radiology team was responsive to our concerns and we received assurance of immediate improvements in a number of standards. This could be sustainable with more engaged and robust leadership.

The EPAU had more established, robust leadership, systems and processes than the radiology department. Our inspection framework required us to report on both services, with ratings that reflect standards of practice in each. However, as radiology provided the greater proportion of scanning services, our summary statement and ratings reflect this proportionately. Where standards of practice relate to the EPAU team, we note this explicitly.

Is the service safe?

Requires improvement ●

Diagnostic imaging

We rated safe as requires improvement because:

- The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it. The trust set completion targets in line with other trusts nationally but did not consistently maintain these.
- Staff did not always understand how to protect patients from abuse and the radiology service had no established links with the safeguarding team. Staff had training on how to recognise and report abuse in the EPAU but in radiology training rates were highly variable.
- Staff did not complete a risk assessment for each patient although they always reviewed prior scan results before starting a procedure. Records completed by radiology/scan staff were limited and not audited for quality.
- The service controlled infection risk well. Staff kept themselves and equipment clean although premises were not always clean. They used control measures to prevent the spread of infection.
- The service did not have enough staff to keep people safe from avoidable harm and to provide the right care and treatment. Staff had the right qualifications, skills, training and experience.
- The service did not always manage reported patient safety incidents well. Staff did not always recognise and report incidents appropriately. Managers investigated reported incidents but did not always identify lessons to reduce future recurrence. When things went wrong, it was not evident staff always apologised and gave patients honest information and suitable support.

However:

- Safeguarding processes in the EPAU were embedded and staff demonstrated extensive knowledge.
- The EPAU service controlled infection risk well. Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.
- The service had suitable equipment and looked after it well.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- Staff in EPAU used monthly leadership and clinical governance information to monitor and improve safety standards.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

We do not currently rate effective for diagnostic imaging.

We found the following areas that require improvement:

- The service provided care and treatment based on national guidance and evidence of its effectiveness, but it was not evident these were always used to benchmark care and outcomes or to drive service improvements.
- Senior staff did not monitor the effectiveness of care and treatment or use a range of measures and findings to improve care. The trust did not compare local results with those of other services to learn from them.
- The service was unable to provide evidence staff were competent for their roles.

Diagnostic imaging

However:

- Food and drink were available for patients while they visited imaging services.
- Staff assessed patients to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different professions worked together as a team to benefit patients. Healthcare professionals supported each other to provide good care.
- Some services were offered outside of standard working hours and on Saturday mornings. Pain film X-ray was available seven days each week.

Is the service caring?

Requires improvement ●

We rated caring as requires improvement because:

- Staff in the main radiology department were generally caring and compassionate but their ability and capacity to do so consistently was hampered by significant departmental pressures and a notable lack of senior oversight.
 - Despite our observations, feedback indicated staff did not always involve patients and those close to them in decisions about their care and treatment.
 - Patients did not always know who they had seen or why they were undergoing certain scans and said staff did not always introduce themselves.
 - Feedback from surveys and complaints indicated a need for more consistent communication from staff when discussing upsetting or challenging news.

However:

- - Staff generally cared for patients with compassion and feedback from patients confirmed that staff treated them well and with kindness.
 - Staff provided emotional support to patients to minimise their distress.
 - We observed staff involve patients and those close to them in decisions about their care and treatment during our inspection.

Is the service responsive?

Good ●

We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.

Diagnostic imaging

- People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice.
- The department provided an out-of-hours service for patients with an urgent need who could not wait until opening hours. Staff provided a 24-hour on call service.

However:

- The on-call system for radiologists was unofficial and tenuous and meant escalation processes were sometimes uncertain. Governance and leadership processes were either not in place or not functioning for this issue.

Is the service well-led?

Requires improvement



We rated it as requires improvement because:

- Radiology managers at all levels in the trust did not have the right skills and abilities to run imaging services and provide high-quality sustainable care. Local leaders in the medicine clinical group, which included radiology, were not aware of all the risks and challenges in the service. There was a significant lack of accountability, capacity and capability at this level of leadership.
- Managers and clinical leads did not have oversight of the overall quality of the service provided. Relationships between staff, senior department leaders and divisional leaders were vague and tenuous.
- The trust had a vision for what it wanted to achieve but workable plans to turn it into action in radiology/scan were not developed with sufficient involvement from staff, patients, and key groups representing the local community.
- Managers did not consistently promote a positive culture that supported and valued staff in imaging services, creating a sense of common purpose based on shared values.
- The trust did not use a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish in imaging services.
- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected in Imaging services.
- The trust did not always collect, analyse, manage and use information well to support all its activities.
- The urgent and critical care directorate did not engage consistently well with patients, staff, the public and local organisations to plan and manage appropriate radiology services.
- The trust was not committed to improving imaging services by strategic learning from when things went well and when they went wrong, promoting training, research and innovation.
- Imaging services learned from exception reporting but there was no comprehensive plan of audit in place to drive improvement and recognise excellence. Training opportunities were hampered by persistent staff shortages. We were offered no examples of innovation and no one we spoke with was research-active.

However:

- Gaps in governance and leadership related to the radiology/scan service and these areas in the early pregnancy assessment unit (EPAU) were significantly more robust and well-established.

Diagnostic imaging

- Although governance arrangements in radiology/scan overall needed improvement, there was some evidence of service improvement on occasion.
- Staff used secure electronic systems with security safeguards.
- Patients regularly nominated staff for recognition for excellent care and service through an engagement programme.
- An active patient experience operational group worked to engage with staff across each division.
- The division and service collaborated with partner organisations effectively.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Birmingham Children's Hospital

Birmingham Children's Hospital
Steelhouse Lane
Birmingham
West Midlands
B4 6NH
Tel: 0121 333 9999
www.bch.org.uk

Key facts and figures

Birmingham Children's Hospital is a specialist paediatric centre, caring for children and young people up to the age of 16.

The hospital has a national liver and small bowel transplant centre and is a global centre of excellence for complex heart conditions, the treatment of burns, cancer and liver and kidney disease.

The hospital is a nationally designated specialist centre for epilepsy surgery and is also a paediatric major trauma centre for the West Midlands.

(Source: Trust website)

Summary of services at Birmingham Children's Hospital

Outstanding   

Our rating of services stayed the same. We rated it them as outstanding because:

- Our rating for safe was good overall. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff completed and updated risk assessments for each patient and removed or minimised risks. The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Our rating for effective was outstanding overall. All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking and peer review were proactively pursued. Staff were consistent in supporting people to live healthier lives, including identifying those who need extra support, through a targeted and proactive approach to health promotion and prevention of ill-health, and they use every contact with people to do so.
- Our rating for caring was outstanding overall. Children and their families were truly respected and valued as individuals and empowered as partners in their care. Staff provided exceptional emotional support to children, families and carers to minimise their distress.

Summary of findings

- Our rating for responsive was outstanding overall. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs.
- Our rating for well-led was good overall. Leaders had the integrity, skills and abilities to run the service. Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

Surgery

Good   

Key facts and figures

Birmingham Children's Hospital (BCH) surgical division provides care for babies, children and young people with the entire range of congenital and acquired conditions at both secondary and tertiary levels. The hospital supports children from all over the UK, both as inpatients and outpatients for emergency and planned surgery.

Surgery at BCH is comprised of the theatres and anaesthetics teams who work in collaboration with specialties such as paediatric surgery, paediatric urology, neonatal surgery, trauma and orthopaedics, plastic surgery, hand and upper limb, burns, rheumatology, neurosurgery, craniofacial, spinal, paediatric dentistry, cleft lip and palate, ear, nose and throat (ENT), cardiac surgery, angiography, ophthalmology, gastroenterology, and transplant. The trust also provides a surgical outreach service to provide support for neonatal patients across the region.

Surgery is undertaken across 15 operating theatres at the Children's Hospital and includes a state-of-the-art hybrid theatre, a high definition laparoscopic theatre (called the OR1) and a new three theatre ambulatory care centre. Patients are cared for across a range of inpatient and day-case wards and include specialist areas such as the neonatal surgical ward, burns unit, cardiac and paediatric intensive care unit.

We undertook an unannounced inspection of the surgery service from 2 April to 4 April 2019. We visited 14 areas where surgical patients received care such as a surgical day case ward, a neonatal ward, burns unit, cardiac care ward, coronary care unit and liver unit. We also visited all the theatre areas, emergency department, paediatric intensive care unit, mortuary and chaplaincy services. We spoke with eight patients and 25 children's and young people's relatives. We also spoke with 32 staff including a clinical anaesthetist, surgical clinical fellow, divisional director, lead

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The safe use of innovative and pioneering approaches to care and how it was delivered was actively encouraged. New evidence-based techniques and technologies were developed and used to support the delivery of high-quality care.
- All staff actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in peer review were proactively pursued, including participation in approved accreditation schemes.
- Staff continually improved their skills, competence and knowledge to ensure high-quality care was delivered.
- Staff were committed to working collaboratively and found innovative and efficient ways for patients to receive care quicker.
- Practices around consent and records were actively monitored and reviewed to improve how children and young people were involved in making decisions about their care and treatment.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Patients, their families and staff had built up strong, caring, respectful and supportive relationships.
- Staff always empowered patients to express their views and to realise their potential. Staff showed determination and creativity to overcome obstacles to delivering care.

Surgery

- The service was flexible, provided informed choice and ensured continuity of care. Staff found innovative ways to ensure, that as much as possible, patients were cared for in environments they were familiar with and by staff they liked.
- There was a proactive approach to understanding the needs and preferences of different groups of patients and their families and to delivering care in a way that met their needs.
- There was a compassionate, inclusive and effective leadership at all levels. Leaders demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff. However, mandatory training targets had not been met in most training modules.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, the service had not achieved its mandatory safeguarding training target for medical staff.
- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough 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 and adjusted staffing levels and skill mix, and gave bank, agency and locum 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 used systems and processes to safely prescribe, administer, record and store medicines. However, they had not been effective at ensuring consistently good practice.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Good  

Our rating of effective went down. We rated it as good because:

Surgery

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious and cultural needs but did not offer an equal range of choice.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking and peer review were proactively pursued.
- The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.
- Staff were consistent in supporting people to live healthier lives, including identifying those who need extra support, through a targeted and proactive approach to health promotion and prevention of ill-health, and they use every contact with people to do so.
- Staff, teams and services were committed to working collaboratively and found innovative and efficient ways to deliver more joined-up care to people who use services. There is a holistic approach to planning people's discharge, transfer or transition to other services.
- Practices around consent and records were actively monitored and reviewed to improve how children were involved in making decisions about their care and treatment. Staff followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Is the service caring?

Outstanding  

Our rating of caring improved. We rated it as outstanding because:

- Children and their families were truly respected and valued as individuals and empowered as partners in their care. Staff provided exceptional emotional support to children, families and carers to minimise their distress.
- Feedback from children and those who are close to them was continually positive about the way staff treat people. People think that staff go the extra mile and their care and support exceeds their expectations.
- Relationships between children and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- Staff always empower people who use the service to have a voice and to realise their potential. They show determination and creativity to overcome obstacles to delivering care.
- Staff found innovative ways to enable people to manage their own health and care when they can and to maintain independence as much as possible.

Is the service responsive?

Good   

Surgery

Our rating of responsive stayed the same. We rated it as good because:

- There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs.
- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs.
- Patients and their families were involved in regular reviews of how the service managed and responds to complaints. The service can demonstrate where improvements have been made as a result of learning from reviews.
- 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. The service included patients in the investigation of their complaint.

Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the integrity, 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.
- 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.
- 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.
- Leaders operated effective governance processes, throughout the service and with partner organisations. 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.
- Leaders and teams used 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- 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.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Surgery

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Mental health services

Background to mental health services

The trust provides community mental health services for young people age 0 – 25. This service is operated as Forward Thinking Birmingham.

Services we inspected included:

- Community-based mental health services for adults of a working age (early intervention psychosis team).
- Specialist community mental health services for children and young people
- Mental health crisis services and health-based places of safety

At the time we did not inspect the following services:

- Child and adolescent mental health wards

Summary of mental health services

Requires improvement ● ↑

Our overall rating for the service provided by the trust was requires improvement. Details of the findings from this inspection can be found in the main summary report.

Mental health crisis services and health-based places of safety

Good   

Key facts and figures

Birmingham Women's and Children's NHS Foundation Trust is the lead provider of Forward Thinking Birmingham. Forward Thinking Birmingham provides urgent care for children and adults up to the age of 25. They also provide a health-based place of safety for patients up to the age of 18.

Urgent care provides both crisis and home treatment to patients. The service is divided into two teams. The child and adolescent mental health service (CAMHS) provides support for patients up to the age of 18 and the adults service supports those aged 18–25.

The crisis teams provide urgent mental health support 24/7. This support is provided for up to 72 hours and is for those patients who may need more than one visit a day and intensive support during a crisis.

The home treatment teams provide appointments at home for those who need a high level of support. Home treatment is a short-term approach designed to help patients move into (or back into) the care of our community hub teams. This support is usually for six to eight weeks. Staff provided support up to 8pm. The crisis team were available to provide support after this time. The home treatment team carried out the seven day follow up visits to patients who had been discharged from inpatient wards.

The health-based place of safety was available for use 24 hours a day, seven days a week. They had capacity for one patient at a time.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

During the previous inspection of July 2017 Forward Thinking Birmingham were rated as inadequate. The urgent care teams and health-based place of safety were part of that inspection.

They were asked to make improvements in the following areas

- The trust did not ensure medicines were stored, dispensed and disposed of safely. The trust did not ensure medicines were stored.
- The provider did not ensure the kitchen area in the health-based place of safety complied with national infection control standards.
- The trust did not ensure that staff who worked in the health-based place of safety were trained in undertaking physical interventions to manage challenging behaviours safely and in a timely manner.
- The trust did not ensure staff followed the standard operating procedures for the seven day follow ups and understand who is responsible for care and treatment when it is shared within teams.
- The trust did not have effective oversight to ensure that all staff who worked within the hubs and urgent care with under 18's were trained to the appropriate levels in children's safeguarding.
- Not all staff were up-to-date with their mandatory training. Not all eligible staff were trained to levels 2 and 3 in safeguarding children.
- The trust did not ensure that all staff were able to follow the lone working policy and did not take steps to ensure the processes were in place for them to do so.

Mental health crisis services and health-based places of safety

During our inspection we found the trust had made improvements in all these areas.

During the inspection visit, the inspection team:

- visited the urgent care teams and the health-based place of safety, looked at the quality of the environment and observed how staff were caring for patients
- spoke with four people who were using the service and two carers
- spoke with the senior managers and team leaders for each team
- spoke with 17 other staff members; including doctors, nurses, administrators and healthcare support workers
- attended and observed a daily meeting, an appointment with a patient in the community and a multidisciplinary team meeting
- looked at 10 care and treatment records of patients and 11 sets of paperwork for patients in the health based place of safety
- carried out a specific check of the medication management and checked the clinic rooms
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean and the physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff working for the mental health crisis teams developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Mental health crisis services and health-based places of safety

- The mental health crisis service and the health-based places of safety were easy to access. Staff assessed patients promptly. Those who required urgent care were taken onto the caseload of the crisis teams immediately. Staff and managers managed the caseloads of the mental health crisis teams well. The services did not exclude patients who would have benefitted from care.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Staff did not always accurately record information in relation to the Mental Health Act in the health based place of safety. This meant staff could not be sure how long a patient had been detained.
- We found some medication errors relating to the disposal of controlled drugs, signage for storage of oxygen cylinders and archived prescription charts which had not been stored correctly
- In the health based place of safety, it was not possible for staff to know if a fire alarm had been activated in the suite as there was no fire panel in that area.

Is the service safe?

Good   

Our rating of safe improved. We rated it as good because:

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- The services had enough staff, who received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

Mental health crisis services and health-based places of safety

- There were some errors in the management of medication. These related to the disposal of controlled drugs, archiving of prescription charts, out of date equipment in the emergency bag and signage for the storage of oxygen cylinders. Managers had ensured that these issues were being resolved by the end of the inspection.
- The health based place of safety did not have a fire panel so staff could not tell if an alarm had been activated in the suite.

Is the service effective?

Requires improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not accurately record information relating patients being detained under the Mental Health Act in the health-based place of safety. This meant that they could not tell if a patient had been detained for longer than the 24hours set out in the Act.
- 54% of staff had completed the MHA training. Managers confirmed that all staff had been booked on to face to face training.

However:

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.
- Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff who worked with patients under the age of 18 understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Mental health crisis services and health-based places of safety

Is the service caring?

Good ● ↑

Our rating of caring improved. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ● ↑↑

Our rating of responsive improved. We rated it as good because:

- The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.
- The health-based places of safety were available when needed and there was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act. Section 12-approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good ● ↑↑

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Mental health crisis services and health-based places of safety

- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well in the CAMHS and adult service. The provider had identified a lack of robustness in learning and changing practice for the health-based place of safety and had carried out a review to identify areas of improvement.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community-based mental health services of adults of working age

Good 

Key facts and figures

This was the first inspection of the Early Intervention in Psychosis service since it transferred to the Forward-Thinking Birmingham organisation in 2017. Prior to that time this team was under the management of Birmingham and Solihull Mental Health Foundation Trust and Worcester NHS Trust.

The service consisted of four teams running out of three different locations across Birmingham. The North and East teams operated out of Finch Road. The South Team operated out of The Oaklands Clinic and the West team operated out of Washwood Heath Health and Wellbeing Centre though it conducted appointments at the Blakesley Centre. The service delivered early intervention in psychosis care to patients ranging from 14 to 35 years of age who were experiencing their first episode of psychosis. Patients could stay on their books for up to three years and received care from nurses, psychiatrists and psychologists. The service also had access to social workers if required though these were provided by external bodies.

During this inspection we: -

- visited Finch Road, The Oaklands Centre, Washwood Heath Health and Wellbeing Centre and the Blakesley Centre.
- undertook four tours of the service where we looked at the environments in which patients were seen. We also viewed all offices where staff worked.
- interviewed 13 patients and 4 carers.
- interviewed the operations manager, three service managers, four Psychiatrists, two Psychologists nine nurses and one support worker.
- inspected 3 clinic rooms to monitor equipment and medication storage.
- observed three team meetings, two multidisciplinary team meetings, two appointments with patients and one care plan approach review.
- viewed 20 medication cards and 19 care records.

Summary of this service

- The service provided safe care. Clinical premises where patients were seen were safe and clean. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.

Community-based mental health services of adults of working age

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude children and young people who would have benefitted from care.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

However:

- Caseload numbers were high across the service. The average caseload across the service was 20 which is higher than national guidance which states that staff in early intervention services should carry a case load of 15 patients. Though clinical supervision was recorded and monitored at a local level, it was not recorded and monitored by the organisation at a senior level. The organisation did not have enough rooms available to ensure that interview rooms were available for appointments. This meant that staff regularly struggled to find space to see patients.

Is the service safe?

Good ●

- All clinical premises where patients received care were safe, clean, well equipped, well-furnished and well maintained.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.

However:

- Caseload numbers were high across the service. The average caseload across the service was 20 which is higher than national guidance which states that staff in early intervention services should carry a case load of 15 patients.
- The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the service that they needed. There had been a project undertaken, in the twelve months prior to our inspection, that had seen a reduction in caseload numbers. This work was ongoing, and the service was entering a round of recruitment at the time of our inspection. The intention was that case load numbers would come into line with national standards at the completion of this project.

Community-based mental health services of adults of working age

Is the service effective?

Good ●

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

However:

- Though clinical supervision was recorded and monitored at a local level, it was not recorded and monitored by the organisation at a senior level.

Is the service caring?

Good ●

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff were knowledgeable of the individual needs of the patients on their caseload. They could provide individualised patient centred solutions to changes in patients' conditions and responded quickly.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.
- Patients and parents and carers were involved in the design and delivery of the service.

Community-based mental health services of adults of working age

Is the service responsive?

Requires improvement

- Though the service had a range of rooms and equipment to support treatment and care we found that all services we visited did not have enough rooms available. This meant that staff often had to delay appointments or conduct interviews in areas that were not suited to the purpose. Though interview rooms were of a suitable size they were sparsely decorated and were not welcoming. Staff stated that this made appointments difficult and was a hindrance in developing strong working relationships with patients and carers. Offices were crowded and loud which meant that it was difficult for staff to engage patients and carers on the phone when they called in. Interview rooms were inadequately soundproofed to ensure that appointments might not be kept confidential.

However:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

Community-based mental health services of adults of working age

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Specialist community mental health services for children and young people

Requires improvement  

Key facts and figures

Birmingham Women's and Children's NHS Foundation Trust is the lead provider of Forward Thinking Birmingham. Forward Thinking Birmingham is the provider of mental health services for children, young people and young adults up to the age of 25 in Birmingham. It provides a single point of access service, a drop-in service, assessment and screening in schools and GP surgeries, urgent care, inpatient care along with community mental health assessment and treatment.

This inspection focused on the community mental health service, known within Forward Thinking Birmingham as "core". The core teams work out of four community hubs across the city:

Birmingham Road (North Community Hub) is at 21-23 Birmingham Road, Sutton Coldfield, West Midlands, B72 1QA

Oaklands Centre (South Community Hub) is at Raddlebarn Rd, Birmingham B29 6JB

Finch Road (East Community Hub) is at 2 Finch Rd, Birmingham B19 1HS

Blakesley Centre (West Community Hub) is at 102 Blakesley Rd, Birmingham B25 8RN

Community services also include specialist teams such as eating disorders, neurodevelopmental and youth offending. These services have specific pathways and were not inspected as part of this inspection.

The community hubs offer multidisciplinary mental health services to children, young people and young adults with mental health difficulties and disorders, ranging in age from 0 to 25 years.

Forward Thinking Birmingham uses the Choice and Partnership Approach (CAPA) model. CAPA is widely used in mental health services for children and young people. It is a service transformation model that combines collaborative and participatory practice with patients. Patients who meet the referral criteria are offered a "choice appointment". This is a face-to-face appointment, which aims to identify what the patient and /or their carer want help with and to establish a shared understanding of the problems. If treatment is indicated, patients are then offered a partnership appointment. In partnership appointments, staff offer specific therapeutic interventions. Staff offer further specialist partnership appointments if patients need specific interventions, for example, family therapy.

Forward Thinking Birmingham has adopted agile working. Agile working is a model which empowers staff to work flexibly. It uses communications and information technology to enable people to work in ways which best suit their needs.

We undertook this inspection to find out whether the trust had made improvements since our last inspection. Our inspection was unannounced (staff did not know we were coming) on the first day, to enable us to observe routine activity. We spent three days inspecting this service.

We last inspected this service in July 2017. At that time, the young adult aspect of the service was managed by a different provider within the partnership. Following that inspection, we issued the trust with requirement notices and told them they must make improvements in these areas:

- The trust must ensure that have a procedure in place so all staff are aware of how to respond to an activated alarm (personal or built in) at all hubs.
- The trust must ensure that all staff are able to follow the lone working policy and all steps are taken to ensure that the processes are in place for them to do so.

Specialist community mental health services for children and young people

- The trust must ensure that all staff adhere to the infection control policy and have the equipment available to do so. The trust must ensure that equipment used to monitor physical health are clean, and cleaned regularly, is calibrated and maintained in accordance with manufacturers guidelines and a record of when this was done is kept.
- The trust must ensure that all substances hazardous to health are kept securely locked away.
- The trust must ensure that fire doors are not propped open.
- The trust must ensure that staff follow the standard operating procedures for seven-day follow-ups and understand who is responsible for care and treatment when it is shared across teams.
- The trust must ensure that medicines are stored, dispensed and disposed of safely. The trust must ensure that staff undertake medicines audit regularly and complete actions from audits.
- The trust must ensure that facilities for storing patient food are cleaned and maintained in accordance with food safety and hygiene standards.
- The trust must ensure that patients' privacy, dignity and confidentiality are maintained at all times. All patient identifiable information must be stored in line with Caldecott principles.
- The trust must ensure that all staff are trained to the required levels in safeguarding adults and children and ensure staff follow up on all safeguarding concerns.
- The trust must ensure that care records are clear, legible, and contemporaneous and reflect all contacts with or about patients.
- The trust must ensure that staff follow the correct procedures when patients do not attend their appointments.
- The trust must ensure that staff have access to information needed to manage patient care is accessible and available for staff. This includes improving agile working practices and complete and contemporaneous care records.
- The trust must ensure that that staff document consent to treatment within patient care records.
- The trust must ensure that there are sufficient numbers of skilled and qualified staff to provide an effective service.
- The trust must ensure that patients have a risk assessment and management plan in place that is complete and updated on a regular basis.
- The trust must ensure that staff complete care plans using the care planning documentation, that care plans are person centred and reflect changes in patients' wellbeing and behaviours.
- The trust must ensure that governance processes are robust and systematic in order to identify and manage risks, monitor performance and provide a safe service for patients and staff.
- The trust must ensure that they review the environmental risk assessments of all hubs and action all concerns identified in the previous assessment.
- The trust must ensure that toys in waiting areas and those used for therapeutic means are cleaned and maintained and a record of cleaning kept.
- The trust must ensure that all areas are clean, there is a regular cleaning schedule in place, and its adherence monitored.

We also told the trust they should make the following improvements:

Specialist community mental health services for children and young people

- The trust should ensure that their plans to make Mental Health Act training mandatory are completed.
- The trust should ensure that all lessons learnt are communicated to all staff.
- The trust should ensure that staff are clear about which age group of patients can access the duty worker.
- The trust should ensure that all staff have access to play therapy equipment needed for clinical work.
- The trust should take precautions to ensure interview rooms used to meet with patients are sound proof.

When we carried out this inspection, we found the trust had made improvements in most of these areas, which we detail later in the report.

During the inspection visit, the inspection team:

- visited each of the four community hubs, looked at the quality of the environment and observed how staff were caring for patients
- spoke with seven people who were using the service and eight carers
- spoke with the senior managers and team leaders for each team
- spoke with 46 other staff members; including administrators, therapists, doctors, student nurses, hub managers, a pharmacist and specialist mental health professionals which included occupational therapists, nurses and social workers
- attended and observed four choice appointments, a therapy session, a multidisciplinary complex case meeting, a safety huddle meeting, and overserved a telephone interview with a patient
- looked at 44 care and treatment records of patients
- carried out a specific check of medication management, including 36 patient prescription charts and checked the clinic rooms
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service improved. We rated it as requires improvement because:

- The number of patients on the caseload of the teams, and of individual members of staff, was high. Staff told us this could prevent them from giving each patient the service they needed. There were not enough staff to deal with the increasing levels of referrals or the backlog of patients waiting to be seen.
- Staff turnover was high across the service, staff expressed feeling overwhelmed and overstretched, and their morale was low.
- The service was not easy to access in a timely manner. Most patients had to wait a long time to get the help they needed because there were high numbers of patients waiting to access the service. The service was not meeting referral to treatment targets.
- Consultation rooms where patients met with staff were not effectively soundproofed in two out of the four community hubs. The rooms were too hot and there were not enough consultation rooms to accommodate the needs of the service.

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- Records did not consistently evidence that patients had been supported to address their physical health needs or had been offered a copy of their care plan.
- The service was generally well led and had improved since our last inspection. The governance processes ensured that procedures relating to the work of the service had improved in most areas. Managers' understanding of pressures on the service, and on staff delivering the service, had improved. Measures had been put in place to deal with the pressures but these needed to go further and become embedded before significant improvement would be seen. High staff vacancies had persisted for long periods and showed only recent improvement. Staff were not given the right tools and support to work to an agile model. High waiting lists dominated activity across the service and staff used words such as "firefighting" to describe the culture they had grown accustomed to working in.

However:

- Staff assessed and treated patients who required urgent care by referring them to the urgent care team or offering an urgent choice appointment. The criteria for referral to the service did not exclude children and young people or young adults who would have benefitted from care.
- The service provided safe care. Clinical premises where patients were seen were safe and clean. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly, even though this may be by the urgent care team. Managers had much improved the way they monitored the waiting lists of patients waiting to access support. Staff assessed and managed risk well and followed good practice with respect to safeguarding. Mandatory training compliance had improved across the service.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. The recording of patient records to reflect this had much improved. Staff provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. A number of bank and agency vacancies were filled by staff who had been in post a long time. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children, young people and young adults. There had been improvements in the recording of capacity in patient records.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.

Is the service safe?

Requires improvement ● ↑

Our rating of safe improved. We rated it as requires improvement because:

- The service did not have enough staff to deal with the volume of referrals and ongoing patient need. The number of patients on the caseload of the teams, and of individual members of staff, was high. This prevented staff from giving each patient the service they needed. Staff were not always able to respond promptly to a sudden deterioration in a patient's health, so patients often had to use the duty system or the urgent care team to get support. Staff monitored patients on waiting lists to detect and respond to increases in level of risk and directed them to the duty worker or

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crisis service. The service had implemented safeguards to better manage the waiting lists of patients waiting to access the service and patients waiting for ongoing support. Managers had better oversight and processes to deal with the risks associated with long waiting lists, but further improvements were required. Without continued close monitoring and action, patients could be at risk of harm.

- Staff turnover was high, which impacted on staff, patients and waiting lists. When staff left, their patients had to be transferred to another worker and there were waiting lists for this.

However:

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff knew their patients and received basic training to keep patients safe from avoidable harm. Staff assessed and managed risks to patients and themselves. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and staff knew how to apply it. The trust had a named nurse and doctor for child safeguarding and each team had a safeguarding lead. There were excellent links with the trust safeguarding team.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care. This had improved since the previous inspection.
- Staff regularly reviewed the effects of medications on each patient's physical and mental health. Staff followed a safe and secure process for storing and recording forms used for prescriptions except at Birmingham Road, which lacked a clear audit trail.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Only 65% of the records we examined showed that staff assessed the physical health needs of patients when they entered the service. Only 66% of the records showed that patients were given ongoing support to manage their physical health needs.
- The trust did not supply data to identify how many eligible staff had undertaken training in the Mental Health Act 1983 (amended 2007). We asked for this data but the trust did not supply it. The trust later told us the number of staff who had completed training in the Mental Health Act was 74% but that data was not available at the time of inspection so could not be verified.
- Only 62% of staff had completed training in the Mental Capacity Act 2005. For a community service, these figures are below what we would expect. The trust later told us the figure had risen to 89% but that data was not available at the time of the inspection so could not be verified.

Specialist community mental health services for children and young people

However:

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented in 80% of the records we looked at.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They were developing a training programme to ensure all staff felt skilled and confident to work with the whole age range of patients. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- The staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Despite low training compliance with the Mental Capacity Act 2005, staff supported patients to make decisions on their care for themselves, proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17, young adults up to the age of 25 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Is the service caring?

Good  

Our rating of caring improved. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.
- Patients and parents and carers were involved in the design and delivery of the service.

However:

- Only 77% of the records we looked at demonstrated that staff had offered patients a copy of their care plan and two, out of the seven patients we asked, said they did not have a copy of their care plan.

Specialist community mental health services for children and young people

Is the service responsive?

Requires improvement ● ↑

Our rating of responsive improved. We rated it as requires improvement because:

- Waiting lists to access support remained high. The service was not easy for patients to access. Patients who did not require urgent care had to wait a long time to access a full assessment and to start treatment. The service was not meeting referral to treatment target times.
- The trust had not responded to a number of reviews which members of the public had left on internet review sites.
- There were not enough consultation rooms and many of rooms used for consultations were too hot to be comfortable. There was poor soundproofing in patient consultation rooms in two of the community hubs. Rooms did not provide privacy and confidentiality. Whilst staff reduced the impact by using a radio at Birmingham Road, they had not identified poor soundproofing was a problem in the first floor rooms at Oaklands Centre. We could hear conversations when in the corridor outside those rooms.

However:

- Referral criteria did not exclude patients who would have benefitted from care and patients could refer themselves. Staff assessed and treated patients who required urgent care by referring them to the urgent care service or offering an urgent appointment. Staff followed up patients who missed appointments.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to post 25 years adult mental health services took place without any disruption to the patient's care.
- The service met the needs of all patients including those with a protected characteristic. Not all sites were accessible for people with mobility needs so staff arranged appointments at other venues to accommodate them. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated formal concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Requires improvement ● ↑

Our rating of well-led improved. We rated it as requires improvement because:

- Staff did not always have access to the information they needed to provide safe and effective care. There were not enough desks for staff to work from in order to carry out essential recording of patient information. The trust had a programme to make extra space available for staff to work from but this had been slow to take effect and was still in progress when we carried out this inspection.
- Essential recording of patient information had improved significantly since the previous inspection but improvements were still required. Trust systems did not fully support a model of agile working; the information technology system was slow to respond to staff moving from one computer to another, not all staff had access to laptops or tablets and the signal at Finch Road was poor. These issues affected staff's ability to use their time effectively and to keep up to date with essential recording.

Specialist community mental health services for children and young people

- Not all staff felt respected, supported and valued. Most reported feeling overwhelmed by their workloads, over-stretched and morale was low as a result. New staff were given large caseloads very quickly and although there were maximum caseloads for staff, many felt the expectations on them were unrealistic. Many felt their professional skills were not used to best effect, for example, specialist therapy staff participating in the duty system. Staff turnover in the service had been high, which had resulted in high vacancy levels. Recruitment had recently improved but staff told us the process took too long and this added additional burdens to their work and wellbeing. Staff shared ideas for improvement but felt leaders did not listen to them because they did not see a positive change. Managers were implementing a review of the Choice and Partnership Approach job plans when we carried out this inspection. However, staff were yet to feel the benefit, in terms of improvements in their wellbeing and morale.
- Some staff reported that the trust did not promote equality and diversity in its day-to-day work. There had been allegations of racial stereotyping amongst some staff, which the trust were addressing in two teams.
- Our findings from the other key questions demonstrated that governance processes had improved at team level and that performance and risk were managed better than we had found in the previous two inspections. However, a number of these improvements were relatively new, and the trust needed to demonstrate that the improvements would be embedded and were sustainable in the long term, particularly considering the continued growth in referrals to the service.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had an improved understanding of the services they managed, were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff reported there were opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children, young people and young adults living in the area. There were local protocols for joint working between agencies involved in the care of children, young people and young adults.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Our inspection team

The inspection was led by Victoria Watkins, Head of Hospital Inspection and Zoe Robinson, Inspection Manager.

The team for the well led review and core services inspections included 17 inspectors, seven of which were mental health inspectors, one mental health act reviewer, four pharmacist inspectors, one executive reviewer and 19 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.