

# Birmingham Women's NHS Foundation Trust

## Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

## Ratings

Overall rating for this trust	Requires improvement	
Are services at this trust safe?	Good	
Are services at this trust effective?	Requires improvement	
Are services at this trust caring?	Good	
Are services at this trust responsive?	Requires improvement	
Are services at this trust well-led?	Requires improvement	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Birmingham Women's Hospital provides a range of health care services to women and families across the West Midlands and the UK which include gynaecology, maternity and neonatal care, as well as a comprehensive genetics service. On average, the trust looks after 50,000 patients a year and carries out over 3,000 operations. The trust also supports home births to women in South Birmingham.

The trust employs around 1,582 staff, 119 medical, 550 nursing and 913 staff are from other disciplines including non-clinical and administrative staff. The hospital has 210 beds, 117 provided for maternity inpatient services, 53 for neonatal intensive care, this includes transitional care ward, intensive care unit, high dependency unit, special care baby unit and 42 for gynaecology services.

We carried out an announced inspection visit from 12 to 14 April 2016 and three unannounced visits on 15, 25 and 27 April 2016. This inspection was part of our comprehensive inspection programme.

We held focus groups with a range of staff in the hospital, including consultants, midwives, nurses, junior doctors, student midwives and nurses, administrative and clerical staff, pharmacists, domestic staff and porters. We also spoke with staff individually.

We inspected and reported the Termination of Pregnancy services (ToPS) under Surgery and Gynaecology services because the volume of ToPS activity did not warrant an individual report. For the same reason, aspects of end of life care for women and babies was inspected and reported under Surgery and Gynaecology and neonatal services.

Overall, we rated this trust as requires improvement. We found that safety and caring was good and effective, responsive and well led required improvement.

The senior team were visible and accessible to staff, and managers were seen as supportive and approachable. Managers were keen to engage and include staff in service development. There were concerns raised in relation to the Termination of Pregnancy service and care pathways in OPD and diagnostic services, however the trust had commissioned an external review to look at issues raised.

There was a positive and enthusiastic culture throughout the hospital. Staff were committed and passionate about their work and proud of the services they offered to patients. Staff were keen to learn and continuously improve and patients were generally very positive about the care and treatment they received at the hospital.

We did not inspect genetics, pathology or fertility services as we have no regulatory remit to do so.

Our key findings were as follows:

### Safe

- In surgery and gynaecology services we observed several occasions where infection control practices were not followed. For example, a member of staff assisted a patient with their wound drain and catheter and then proceeded to serve patients at lunch without cleansing their hands. A patient had been moved to a side room with an infectious condition, we observed a member of staff leaving the room and did not sanitise their hands and went on to make tea for patients.
- Not all staff complied with the "bare below the elbows" policy. We saw two staff serving food, who were wearing jewellery such as a watch, a large ring (with stone) and large looped earrings.
- There were no reports of Methicillin-resistant *Staphylococcus aureus* (MRSA) Methicillin-sensitive *Staphylococcus aureus* (MSSA) or *Clostridium difficile* reported between December 2014 and December 2015 trust wide. Patients received care in a visibly clean and suitably maintained environment.
- There was a high standard of cleanliness throughout most services. The large majority of staff were aware of current infection prevention and control guidelines. They were supported by staff training and the adequate provision of facilities and equipment to manage infection risks.
- Maternity inpatient service met the national benchmark for midwifery staffing as set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for

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the Organisation and Delivery of Care in Labour) with a ratio of one midwife per 28 patients. There were sufficient nursing staffing levels across surgery and gynaecology.

- Neonatal staffing levels did not meet the British Association of Perinatal Medicine (BAPM) standards of nurse to patient ratio. However, neonatal staff worked extra hours to fill gaps on the staffing rota which ensured care and treatment was delivered in a timely manner.
- There were challenges to fill sonography vacancies in the outpatient department which resulted in long waiting times.
- There were sufficient numbers of consultants to provide good quality care and treatment for patients in line with Royal College for Obstetricians and Gynaecologists guidance.
- From January 2014 to June 2015 maternity inpatients showed there was 90-120 hours coverage per week which was below the Royal College for Obstetricians and Gynaecologists (RCOG) recommendations of 168 hours for the number of births.
- BWH offered specialist services to women with often complex medical conditions. The Trust had reported five maternal deaths in the last 26 months. An external review had been commissioned and was underway to review the trusts investigations into each death in order to identify any common themes or patterns. We reviewed the external report and saw there were no common themes for the five cases.
- A perinatal and maternal mortality and morbidity meeting was held monthly, this involved multidisciplinary team members (MDT), Minutes and lessons learnt were shared widely across the service.

## Effective

- We noted the information on medical terminations of pregnancy did not include the risk of a late gestation foetus showing 'signs of life' and the potential requirement to register with the coroner.
- Several nurses across ToPs expressed concerns to us as they had not received training that would equip them to deal with the physical and emotional aspects of advanced gestation abortions.
- In addition within ToPS two incidents (trust data showed five for Quarter four in 2015/16)) reported on the trust's incident reporting system, there were other occasions when the condition of the foetus had given them cause for concern and the action they should have taken was unclear.
- Within ToPS we saw the root cause analysis of an incident that led to a serious case review underway at the time of our inspection indicated teamwork between the abortion care service, ward team and bereavement team and wider medical team needed to be strengthened as sharing of information in and out of the service between the MDT was inconsistent.
- Patients reported unnecessarily lengthy periods when they were unable to eat and drink prior to undergoing surgery and we found there were variations in the instructions about this for patients, depending on the anaesthetist involved. The trust had been unable to reach a consensus in order to achieve a consistent approach and reduce the amount of time patients were unable to eat and drink to a minimum.
- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- Care and treatment were delivered throughout the trust in accordance with evidence-based guidelines. The trust had a system for receiving, recording, assessing and monitoring compliance with NICE guidance. Quarterly reports were provided for commissioners as part of the quality contract requirements.
- Patients' religious and cultural needs were considered and food was provided in accordance with their requirements. Staff gave appropriate and discreet support to those patients who needed help with eating and drinking. Specialist dietary support was available to patients whose condition indicated or required a specialist diet.

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- Parents were supported in their chosen method of feeding. When mothers chose to breast feed but were unable to due to the baby's condition, facilities were provided for expressing breast milk in private.

## Caring

- We saw excellent care provided across the trust in many areas, particularly in inpatient maternity where the care was outstanding.
- We observed caring and compassionate interactions between staff and women, when new mothers felt they needed to talk or they felt anxious staff would speak with them even in the middle of night and looked after their baby overnight so the mother could catch up on their sleep.
- Excessive waiting times in antenatal clinics in some cases was more than five hours and some women were told to attend the hospital twice in one day with split appointments for bloods and a scan.
- Patients with pregnancy loss or termination of pregnancy did not have the same range of options for disposal of remains as other patients/families. The bereavement and spiritual care service stated its intention to improve this.
- Although there was access to translation services for people for whom English was not their first language, some staff within surgery services perceived the use of family members to interpret for patients to be the first option.
- There was a specialist midwifery team for vulnerable women which comprised of a specialist midwife in perinatal mental health, substance and alcohol misuse, teenage pregnancy, female genital mutilation, smoking cessation and high risk pregnancy.
- Women with a learning disability were supported through an integrated acute and community approach.
- Patients' religious and cultural needs were met through a multi-faith chaplaincy and a bereavement service for parents and those close to them who had lost their babies.

- Six parent flats were available close to the neonatal intensive care unit (NICU) for families to stay near to their baby.

## Responsive

- We noted the information on medical terminations of pregnancy did not include the risk of a late gestation foetus showing 'signs of life' and the potential requirement to register with the coroner.
- Bed occupancy for 2014/2015 was between 64% and 72%, however for 2015/2016 the bed occupancy ranged between 72% and 82% and both years were higher than the national average.
- Within neonatal services bed capacity leads worked six days a week to organise patient transfers and admissions. The unit did not close to patients in need of admission however, at times the unit would delay ex-utero (babies already born) transfers until cots were vacant and staffing levels were appropriate.
- One couple in the antenatal clinic who complained about waiting for more than five hours on their last visit to have their blood tests, scan and doctor's appointment. They waited on the day of our inspection for the triage appointment for three hours and then waited a further two hours to see a doctor.
- One patient explained they had a blood test carried out in the morning and were told to return for a scan in the afternoon.

## Well led

- An independent review of the trusts' governance arrangements by an independent nationally respected organisation was carried out in March 2016, prior to its planned acquisition by Birmingham Children's Hospital. The findings of this review and our findings were similar.
- Risk management across directorates was variable, governance and risk management structure across maternity inpatient maternity community, surgery and gynaecology and neonatal services was well embedded.

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- The board were largely aware of the current status of the effectiveness of governance arrangements at the trust and were aware of the need for further development across its services.
- We found the (BAF) which forms part of the NHS England risk management strategy and is the for identification and management of strategic risks required further development. Three key risks were identified; staffing, finance and flow, linked specifically to the antenatal pathway. We were not assured that the BAF was clear who had responsibility and that risks were fully identified, understood and managed appropriately.
- There were challenges around governance arrangements and risk management with termination of pregnancy service. For example, the new contract for the termination of pregnancy service had commenced in January 2015. At the time of the inspection training for staff had not been formalised despite concerns expressed by staff about the need for clarity regarding actions to be taken.

We saw several areas of outstanding practice including:

- The symptom specific triage assessment card within inpatient maternity services delivered consistency and clear targets for the triage process.
- Video books were available for women across acute and community services who did not speak or read English.
- The trust was awarded a (SDIP) grant by local commissioners to pilot a three year project to set up a Homebirth Service, one of its kind in the region.
- Funding was sought from the Local Education Training Council (LETC) to fund a two year foundation degree to enable the maternity assistants to acquire the necessary competencies to assist the midwife at home-births.
- Staff within the neonatal services introduced the routine use of pulse oximetry for all babies within 24 hours of birth or prior to discharge. This has been identified as significant in the early detection of critical congenital heart defects prior to the

deterioration of the baby. The business case and rationale for testing has been shared nationally and around 20% of hospitals now routinely perform this test.

- Gynaecology services had been successful in becoming an accredited British gynaecology endoscopy (BSGE) centre for complex endometriosis. This is a regional specialist service whereby women with complex endometriosis are referred and includes medical, pain related and surgical management.
- The Trust as a whole achieved Baby Friendly status in April 2013. A new approach and standards have been developed by UNICEF and Maternity service has been reaccredited under the new standards.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

## **Actions the trust MUST take to improve;**

- Healthy Start vitamins must be stored securely in all community maternity team offices.
- Medicines prescribed and stored in line with the trust policy, particularly intravenous fluids.
- All community midwives must attend safeguarding supervision in line with Department of Health requirements (Working Together to Safeguard Children, 2015).
- Improve the application of infection prevention and control procedures in relation to the use of personal protective clothing and equipment and hand hygiene.
- Properly maintain all equipment and medical devices.
- Provide secure storage for patient records across all clinical areas.
- Ensure the project to develop a second emergency theatre team is progressed in a timely manner.
- The trust must ensure all HSA1 certificates for termination of pregnancy are fully completed by the registered medical practitioners signing them.

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- Identify, monitor and mitigate all risks relating to developing the complex abortion service pathway. In particular in respect of processes required and the impact on staff and patients of distressing elements of late gestation termination.
- Provide training to ward staff caring for complex abortion services patients in the appropriate procedures for responding to late gestation termination of pregnancy where the foetus may be indicating signs of life.
- Ensure team work between the complex abortion care service, ward teams and bereavement team and wider medical teams are strengthened to mitigate risks involved in late gestation termination of pregnancy.
- Take steps to ensure multi-disciplinary team work is improved where clinicians from other trusts are contributing the care of patients.
- Clarify the method clinician's should use to establish consent to termination of pregnancy from adult patients with learning disabilities.
- Ensure that the data collected for the Neonatal Audit Programme (NNAP) reflects the care given within the unit.
- Ensure staff receive mental capacity training in line with trust guidance.
- Implement a system to assess, monitor and improve the waiting times across clinics in the outpatients and diagnostic departments.
- Mitigate the risks relating to the health, safety and welfare of service users by regularly reviewing the risk register and include a timescale in completing any risks identified.
- Reduce the waiting times in diagnostics department by having sufficient numbers of qualified staff.
- Provide community maternity staff with secure facilities and guidance to retain old diaries.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Birmingham Women's NHS Foundation Trust

Birmingham Women's Hospital is the sole hospital site operated by Birmingham Women's Hospital Foundation Trust which serves more than 50,000 patients a year and carries out over 3,000 operations. The trust also supports home births to women in South Birmingham.

The hospital is a major obstetrics, gynaecology and neonatology research hospital, one of only two specialist trusts in the UK. The hospital has 210 beds, 117 provided from maternity inpatient services, 53 from neonatal intensive care, this includes transitional care ward, intensive care unit, high dependency unit, special care baby unit and 42 from gynaecology services. The trust provides community maternity care from four designated teams and also from a home birth team.

The trust is subject of a planned acquisition by Birmingham Children's Hospital Foundation Trust (BCHFT) and there have been several changes to the executive board over the past few months with interim posts. The aim is to merge both hospitals into one organisation by 2017 and to "develop a shared vision to become the best women's and children's healthcare built around the whole family".

At the time of the inspection it was not decided where the location of the new organisation would be sited or the name of the new organisation. It is expected that both hospitals will continue to operate from their respective sites until such time.

This inspection was part of our comprehensive inspection programme.

## Our inspection team

Our inspection team was led by:

**Chair: Jenny Leggott** retired NHS Trust Director of Nursing and Midwifery- Nottingham University Hospitals NHS Trust.

**Head of Hospital Inspections: Tim Cooper** Care Quality Commission

The team included an inspection manager, eleven CQC inspectors and a variety of specialists including; an obstetrician and gynaecology consultant; neonatal consultant, senior radiographer, director of operations, deputy medical director, supervisor of midwives, acute and community midwives, paediatric nurse and adult and children's safeguarding lead.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held about Birmingham Women's Hospital NHS

Foundation Trust and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We attended two patient focus groups; The Urogynae Patient Focus Group on the 7 April 2016 and also the Family and Patient Advisory Focus Group on the 12 April 2016 to listen to people's views and experiences of Birmingham Women's Hospital. Some people also shared their experiences by email and telephone.

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The announced inspection of Birmingham Women's Hospital took place on 13 and 14 April 2016.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested and held a focus group with non-executive directors and trust governors.

We talked with patients and staff from all the ward areas, outpatients and community services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We undertook an unannounced inspection of the trust on 15, 25 and 27 April 2016.

## What people who use the trust's services say

The NHS Friends and Family Test response rates were consistently better than the England average for nine out of 12 months from January 2015 to December 2015. The trust has met or surpassed its target of 72% for all months during this period. This indicated that most patients would be likely to recommend the trust as a place to have care and treatment.

Responses were received from 202 patients at Birmingham Women's NHS Foundation Trust to the CQC's Survey of Women's Experiences of Maternity Service in

2015. Results were comparable to other trusts in England. The trust actively sought feedback from patients, who were positive about the quality of care and treatment provided.

Before our inspection we received mixed feedback from people who used the service through 'Share your knowledge' online forms. Largely, people were positive about the care and treatment delivered to women and their babies.

## Facts and data about this trust

Birmingham Women's Hospital is the only acute site providing services as part of Birmingham Women's NHS Foundation Trust. There are 210 beds on the site, which comprises 117 for maternity inpatient services, 53 for neonatal intensive care, this includes transitional care ward, intensive care unit, high dependency unit, special care baby unit and 42 for gynaecology services. There are four community teams and a specialist home-birth team, all providing care to people of South Birmingham. The trust employs around 1,582 staff, 119 medical, 550 nursing and 913 are from other disciplines.

The trust delivers a range of health care services to women and families across the West Midlands and the UK which include gynaecology, maternity and neonatal care, as well as a comprehensive genetics service.

On average the trust looks after 50,000 patients a year, carries out over 3,000 operations and delivers more than 8,000 babies.

The health of the population in Birmingham is varied compared with the England average. Deprivation is higher than average and about 30% of children live in poverty. Life expectancy for women in the Birmingham area is lower than the England average.

Smoking related deaths and the under 75 mortality rates for cardiovascular and cancer are worse than the England average. Obesity in children and infant mortality are worse than the England average. For adults, obesity, alcohol related stays in hospital and recorded diabetes are all worse than the England average. Priorities in Birmingham include tackling childhood obesity, statutory homelessness, and reducing the numbers of vulnerable children and adults.

The trust has an annual income of around £97m and a current deficit of around £4.5m.

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## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p>We found safe was good because;</p> <p>The trust was aware of its role in relation to the duty of candour regulation that was introduced in November 2014. We looked at investigation reports of ten serious incidents that had taken place since the duty of candour regulation came into force, all reports met the regulation requirements.</p> <p>All relevant staff had received appropriate levels of training for safeguarding children and safeguarding of vulnerable adults, supported by robust policies and procedures.</p> <p>There were established systems for reporting incidents and ‘near misses’. Staff had received training and were confident in the use of the incident reporting system. There were good examples of learning from incidents. Staff in all clinical areas were able to describe changes in practice following incident investigations.</p> <p>Nursing, midwifery and medical treatment was delivered by caring and committed staff and there were sufficient numbers of suitably qualified staff across many services to keep patients free from avoidable harm. There were challenges to fill sonography vacancies in the outpatient department which resulted in long waiting times and neonatal staffing levels could not meet the British Association of Perinatal Medicine (BAPM) standards of nurse to patient ratio. However, this did not affect timely care and treatment for babies.</p> <p>Robust risk assessments and early warning scores were used across all services. Maternity inpatients had developed a number of innovative symptom-specific triage assessment cards, adopted by other trusts nationwide. Resuscitation equipment was readily available throughout each service, however the trust had challenges around completion of daily checks by staff and this was placed on their risk register.</p> <p>A pharmacy team provided clinical services to ensure patients’ medicines were handled safely and an onsite pharmacy provided both inpatient and outpatient dispensing of medicines which allowed the clinical pharmacy team to have more time directly on the wards. An antimicrobial pharmacist worked within the trust to improve antibiotic use. They were further supported by an antibiotic stewardship committee and consultant microbiology support was shared across both Birmingham Women’s and Birmingham Children’s Hospitals.</p>	<p><b>Good</b> </p>

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However, we also saw;

In surgery services, safe infection prevention and control practices were not always followed by staff and numerous pieces of equipment which were labelled as clean were not. Within the same service equipment such as electric beds, weighing scales, and fans had not been serviced and maintained in line with safety requirements and we found consumable items such as swabs and liquids which were past their expiry date in the clinical areas.

Medicines management and storage required improvement in a number of areas; On ward 1 and 8, we found intravenous fluids which were not securely stored. On ward 8 an oxygen cylinder was not secured safely. On the same ward we further identified expired medicines in an unlocked room. We found loose strips of medicines not stored in the original container were available in the medicine trolley. In the antenatal clinic, the medicine store room was not locked and medicines requiring cool storage were stored in an unlocked medicine refrigerator. There were challenges around incorrect prescribing by junior doctors of a medication to reduce the risk of venous thromboembolism. However, a new prescription chart for venous thromboembolism was developed to address the problem.

## **Duty of Candour**

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust was aware of its role in relation to the duty of candour regulation that was introduced in November 2014. It sets out specific requirements providers must follow which includes an apology to patients.
- We looked at investigation reports of 10 serious incidents that had taken place since the duty of candour regulation came into force. We carried out an extensive review of all related documents which detailed complexity of each case, complaint and contact with the families were transparent and each file contained written evidence of apologies to the families concerned.

## **Safeguarding**

# Summary of findings

- All relevant staff had received appropriate levels of training for safeguarding children and safeguarding of vulnerable adults, supported by robust policies and procedures. Safeguarding training included information about female genital mutilation to raise staff awareness of the issue.
- The trust set a target of 100% for safeguarding children training level 1, and they achieved this. For level two, they set a target of 85% and they achieved 97%. For level three, the target was 85% and they achieved 87%. For adult safeguarding, level one the trust achieved 100% against a target of 85% and for level two the trust achieved 97%.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people and understood their responsibilities in identifying and reporting any concerns. Safeguarding practice was supported by a trust wide safeguarding team that staff could access for advice and support.

## Incidents

- There were established systems for reporting incidents and 'near misses'. Staff had received training and were confident in the use of the incident reporting system.
- The latest national reporting and learning system (NRLS) data showed the trust reported 1,468 incidents to NRLS January 2015 to January 2016. Of these, 96% were no harm or low harm (70% no harm). There was some delay to reporting incidents; 33% of incidents took 31 to 60 days to report, with 23% taking more than 90 days to report. Obstetrics specialty had the most incidents reported (838), accounting for 57% of all incidents. Gynaecology accounted for 18% and Neonatology for 17% of all incidents.
- The main three types of reported incidents related to treatment, procedure which accounted for 19%, clinical assessment (including diagnosis, scans, tests, assessments) made up 17% and access, admission, transfer, discharge (including missing patient) was 15%. There was one never event reported and 31 serious incidents between October 2014 and September 2015.
- There were good examples of learning from incidents. Staff in all clinical areas were able to describe changes in practice following incident investigations.

## Nurse and Midwifery staffing

- Maternity inpatient service met the national benchmark for midwifery staffing as set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth:

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Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of one midwife per 28 patients. There were sufficient nursing staffing levels across surgery and gynaecology.

- Neonatal staffing levels could not meet the British Association of Perinatal Medicine (BAPM) standards of nurse to patient ratio. However, neonatal staff worked extra hours to fill gaps on the staffing rota which ensured care and treatment was delivered in a timely manner.
- Maternity support workers and healthcare assistants assisted midwives and nurses in caring for women and their babies through the stages of pregnancy, childbirth and the first few days of birth based in the hospital and across the community teams.
- Volunteers formed part of the workforce and worked across the Antenatal Clinic, on the Meet and Greet desk, on the Maternity wards, in the Radiology department, Milk Bank, Neonatal Unit and as administrative support volunteers within various departments.
- There were challenges to fill sonography vacancies in the outpatient department which resulted in long waiting times, in some cases in excess of five hours. Across the four maternity community teams there was a vacancy factor of 5.93%, although the recruitment programme was underway, the trust found it challenging to recruit to community midwives.
- The trust had previously ceased the recruitment programme campaign to re-evaluate staffing levels in all areas. However, in the weeks prior to the inspection the recruitment programme had recommenced. Staffing levels were calculated using a recognised tool and was regularly reviewed.

## Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- There were sufficient numbers of consultants to provide good quality care and treatment for patients in line with Royal College for Obstetricians and Gynaecologists guidance.
- The trust had a higher proportion of registrars and consultants than the England average but a lower proportion for junior and middle grade doctors.
- From January 2014 to June 2015, data from maternity inpatients showed there was 90-120 hours consultant coverage per week which was below the Royal College for Obstetricians and Gynaecologists (RCOG) recommendations of 168 hours for the number of births. Recruitment plans were in place to

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increase consultant posts although the RCOG recognised in its recommendations that the larger the unit, the greater the difficulty in achieving the recommendations purely on financial terms.

- Junior medical staff were well supported and provided with excellent teaching and learning opportunities, however the trust was reviewing the role of the junior doctors to ensure their skills were utilised appropriately across all areas.

## Monitoring safety and responding to risk

- Robust risk assessments and early warning scores were used across all services. Maternity inpatients had developed a number of innovative symptom-specific triage assessment cards, adopted by other trusts nationwide.
- Community midwives referred women with identified risks at the booking visit for obstetric review and onward pregnancy planning. Problems identified throughout the woman's pregnancy were also referred for obstetric review on the Day Assessment Unit (DAU).
- In the operating theatre, the world health organisation (WHO) safer surgery checklist was completed appropriately for gynaecology and termination of pregnancy surgeries. Quarterly audits showed that 97% compliance in 11 of the 12 months of 2015. The one month in April 2015 had a compliance rate of 92%. There was no further audit data available for the three months leading up to the inspection in April 2016.
- Resuscitation equipment was readily available throughout each service, however the trust had challenges around completion of daily checks by staff and this was placed on their risk register. Staff were consistently not carrying out daily checks. The reason given by a member of the executive team was due to complacency.
- Across all directorates, 88% of staff had completed their mandatory training in Adult Basic Life Support Training (ABLS) against the trust target of 85%.

## Medicines management

- A pharmacy team provided clinical services to ensure patients' medicines were handled safely and an onsite pharmacy provided both inpatient and outpatient dispensing of medicines which allowed the clinical pharmacy team to have more time directly on the wards.
- An antimicrobial pharmacist worked within the trust to improve antibiotic use. They were further supported by a combined antibiotic stewardship committee with Birmingham Children's Hospital.

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- The Trust Medicine Safety Officer (MSO) attended the Clinical Improvement Group as well as the monthly Patient Outcome Committee and the Drug and Therapeutics Committee which identified and discussed medicine safety issues. In particular they noted any potential trends in medicine incident reporting where action could be taken.
- Trust wide learning from medicine incidents were shared with ward managers, matrons, clinicians, pharmacists and Non-Medical Prescribers via e-mail.
- Regular audits were undertaken on wards to ensure that controlled drugs, which required extra security and recording, were safely stored and recorded. We found that controlled drugs were stored safely and recorded.
- The neonatal unit was trialling a secure electronic key system which tracked the key to a named person, this enabled a secure medicine system, we saw this worked well in practice and senior staff were confident the system would be a permanent one.
- Medicines were not always stored securely and safely. On ward 1 and 8, we found intravenous fluids which were not securely stored. On ward 8 an oxygen cylinder was not secured safely. On the same ward we identified out of date medicines in an unlocked room. We found loose strips of medicines not stored in the original container (which is good practice) were available in the medicine trolley.
- In the antenatal clinic, the medicine store room was not locked and medicines requiring cool storage were stored in an unlocked medicine refrigerator.
- There were numerous incidents of incorrect prescribing of a medication by junior doctors to reduce the risk of venous thromboembolism. We were told that both the clinical pharmacists and midwives were aware of the problem and were checking the prescriptions all the time. Headlines of the week, newsletter dated 19 to 25 April 2016 reminded inpatient staff to 'check the prescription chart carefully before administering medication'. A new specific prescription chart for venous thromboembolism was introduced to address the problem. It was early days, however, staff explained it was working well.

## Are services at this trust effective?

We found effective required improvement because;

Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and

**Requires improvement**



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procedures via the trust intranet. However we noted the information on medical terminations of pregnancy did not include the risk of a late gestation foetus showing 'signs of life' and the potential requirement to register with the coroner.

There was no agreed differential care pathways for patients with complex needs planned to undergo abortions. Staff needed guidance in best practice and 'sensitive management care' of patients' emotional and psychological needs may significantly differ due to the reason for the decision to terminate the pregnancy, however there was minimal support.

There was no established pathway in place for addressing consent to treatment for women with a learning disability.

Several nurses from the termination of pregnancy service expressed concerns had not received training that would equip them to deal with the physical and emotional aspects of advanced gestation abortions.

Starvation times for patients undergoing surgery needed to be reviewed and strengthened as some patients were without food and fluids for 12 hours pre-operatively which could have impacted on their recovery.

However, we also saw;

A wide range of pain relief options was available to women supported by information to help them make an informed choice.

Patient outcomes were monitored effectively using a maternity dashboard system.

The target for breastfeeding initiation rates was being met and there was a detailed action plan to address the neonatal readmission outlier.

Staff were provided with support and education to be competent in their practice and staff induction was comprehensive and up to date.

We observed excellent multidisciplinary team work across all services, although information sharing could be improved.

Care and treatment for women and babies was planned and delivered in line with current evidence based guidance.

## **Evidence based care and treatment**

- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures via the trust intranet.

# Summary of findings

- The care of women using maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- Care and treatment were delivered throughout the trust in accordance with evidence-based guidelines. The trust had a system for receiving, recording, assessing and monitoring compliance with NICE guidance. Quarterly reports were provided for commissioners as part of the quality contract requirements.
- The trust participated in a range of clinical audits, and actions were taken in response to the findings to improve patient outcomes. The audit programme was developed annually in partnership with the clinical lead from each directorate and support from the clinical audit team. The programme included trust priorities, responses to incidents, national audits, audits against NICE guidance and any re-audits that were due during the year. Implementing the audit plan was monitored by the clinical audit team and reported to the divisions and governance committees.
- The neonatal unit had achieved UNICEF level three Baby Friendly Initiative. The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding. This meant that the unit had to achieve specific standards, had policies and processes in place to support these.
- However we noted the information on medical terminations of pregnancy did not include the risk of a late gestation foetus showing 'signs of life' and the potential requirement to register with the coroner. We heard outpatients' clinic gave this information verbally to patients.
- Nurses on wards caring for complex abortion services patients confirmed they had no agreed differential care pathways. They needed guidance in best practice and sensitive management care of a foetus where the patients' emotional and psychological needs may significantly differ due to the reason for the decision to terminate the pregnancy.

## Nutrition and hydration

# Summary of findings

- We saw jugs of water were provided at each patient's bedside and there were regular hot drinks rounds. Patients told us they were offered plenty of drinks and if a nurse saw their jug was empty they would ensure it was re-filled.
- Women who accessed the birth centre used 'smoothie' making equipment to help meet their nutrition and hydration needs in labour and women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements.
- Patients who were due for surgery were instructed not to have anything to eat from 12 midnight on the day of their admission for their operation and to have no fluids from midnight if they were scheduled for surgery in the morning or from 6.am if their surgery was scheduled for the afternoon. One patient told us their surgery had been later than expected due to the need for an emergency patient to be added to the list and they had not gone to theatre until after lunch, having been without food from midnight.
- This meant patients sometimes were without food and fluids for 12 hours pre-operatively which could have impacted on their recovery. Time without fluids was at least five hours which is much longer than the two hours which the Royal College of Anaesthetists recommends.

## Patient outcomes

- The trust collected monthly data on outcomes of women's care and treatment and incorporated it into a monthly performance and quality report. They benchmarked their performance against other maternity services within the West Midlands. The hospital's performance statistics in the percentage of women achieving a normal vaginal birth were below the national target but were comparable to other tertiary level maternity services. This was because of the higher risk and complexity of women referred for this specialist service.
- One to one care in labour was audited and reported on the risk dashboard, Since August 2015 all women in active labour at the hospital had received one to one care.
- Women presenting in triage were seen in a timely fashion. Of these, 99% were seen within 30 minutes of their arrival, against the trust's target of 95%.
- Across community maternity services the number of women booked before 12 weeks gestation in December 2015 was 95% which was above the trust target of 90%. The trust capped the number of bookings in order to ensure that safe care could be

# Summary of findings

provided to women throughout their pregnancy, birth and postnatal period. Capping maternity bookings is a nationally recognised process to ensure the service can manage activity within the capacity it has.

- There were 364 women who booked with the home birth team between April 2015 and March 2016. A total of 112 women started labour at home, of these 98 birthed at home.
- The average length of stay for elective gynaecology was in line with the England average (August 2014 – July 2015). The average length of stay for non-elective gynaecology was below (better than) the average at 1.1 days as compared to an England average of 1.9 days in the same period. This meant that patients were able to leave hospital as soon as possible without their discharge being delayed. National data indicated that the relative risk of being re-admitted to hospital was higher than the England average for elective gynaecology and lower than the England average for non-elective gynaecology (August 2014-July 2015).
- A root cause analysis of an incident in termination of pregnancy service took place in February 2016 identified a patient had not been referred to the correct clinical care pathway from the fetal medicine service. This had contributed to the poor outcomes experienced by the patient.
- Unplanned neonatal readmission data for January 2015 to November 2015 highlighted a 1.4% readmission rate of neonates, this was similar to the trust target of 1.3%.
- Antenatal clinics measured key performance indicators (KPI'S) on reducing the waiting times in clinics for women for; screening, bookings and taking bloods. Twelve months previous the department had scored low at 9%, following implementation of the history booking system which helped to speed up the process, this had increased to 35%, However it was acknowledged there was significant room for improvement.
- Diagnostic imaging department were involved with research into scanning and miscarriages, the data collated helped to reduce the number of scans required for each patient. The department is an Imaging Services Accreditation Scheme (ISAS) assessor.

## Competent staff

- Several nurses from the termination of pregnancy service expressed concerns that they had not received any training that would equip them to deal with the physical and emotional aspects of advanced gestation abortions.

# Summary of findings

- They said, in addition to two incidents [trust data showed five incidents for Q4 2015/16] they reported on the trust's incident reporting system, there were other occasions when the condition of the foetus had given them cause for concern and the action they should take had been unclear. However we noted the RCA for a third incident reported the impact as 'low' because all staff had responded appropriately on that occasion due to learning embedded from the first incident.
- Ward nurses told us the complex abortion care service staff did not have a presence on the ward, and despite the reported incidents there was no written guidance for staff and no training plan. However, there was some guidance, about foetal signs of life, being trialled on wards at the time of our visit.

## **Multidisciplinary working**

- We observed and were told about good multi-disciplinary working across all core service areas. A multi-disciplinary approach was actively encouraged and we saw many examples of co-ordinated care as a result.
- Effective team working between wards and departments was observed with appropriate interactions and interventions between staff seen.
- Staff across acute and community services provided good MDT working between midwives, nurses, consultants, doctors and non clinical staff.
- The sharing of information across the disciplines was largely well managed. Each discipline listened to and valued the contribution of their colleagues.
- However, a root case analysis of an incident from the termination of pregnancy service that led to a serious case review carried out at the time of our inspection indicated that communication and information sharing required improvement. Teamwork between the abortion care service, ward team and bereavement team and wider medical team needed to be significantly strengthened.
- We noted the trust included in its operational policy for women seeking abortion care consideration of needs of 'vulnerable' women during assessment. Also included were clear directions for clinicians about responding to children under 16 seeking abortion care, children 13 and under and reference to information on the Gillick competence.
- One patient whose file we looked at had requested a surgical termination of pregnancy was noted on record as 'severely learning disabled' and was accompanied by a parent.
- The assessing medical practitioner had recorded the patient as 'Fraser Competent' but did not note how this decision was

# Summary of findings

arrived at. Fraser Competent is a term used to describe a child under 16 who is considered to have sufficient maturity and intelligence to understand the nature and implications of the proposed treatment (for sexually transmitted infections and termination of pregnancy) and contraceptive advice without parental knowledge or consent. We raised this with the trust after our visit and it undertook to investigate it.

## **Consent, Mental Capacity Act & Deprivation of Liberty safeguards**

- Staff across many services demonstrated the appropriate skills and knowledge in obtaining verbal, informed and written consent from patients prior to the delivery of care and treatment.
- Training on mental capacity assessment (MCA) and deprivation of liberty safeguards (DoLS) was included in safeguarding training and staff understood the legal requirements of both .
- The trust had issued staff with cards outlining their duties and professional obligations relating to the Act.
- We reviewed the records of a patient who had been admitted to the gynaecology ward at the time of our visit. We found a mental capacity assessment had been completed, however, the specific decision was not clearly documented, there was no information about other options considered and the reason why surgery was necessary was not included in the best interest decision making documentation.

## **Are services at this trust caring?**

We found caring was good because;

Feedback from patients and relatives was positive about the care and treatment provided by acute and community staff, particularly in inpatient maternity where the care was outstanding.

We found people were treated with dignity, respect and kindness during their interactions with staff and care was planned and delivered that took into account the wishes of the patients and the parents of the babies who needed special care. Patients were active partners in their care and women and their families felt emotionally supported.

## **Compassionate care**

- We saw excellent care provided across the trust in many areas, particularly in inpatient maternity where the care was outstanding.

**Good**



# Summary of findings

- We observed caring and compassionate interactions between staff and women, when new mothers felt they needed to talk or they felt anxious staff would speak with them even in the middle of night and looked after their baby overnight so the mother could catch up on their sleep.
- Parent's wishes were considered throughout care in the neonatal intensive care unit (NICU) especially during 'comfort care'.
- Where babies were not expected to survive, families were encouraged to stay within the unit to be close to their baby at the end of life.

## **Understanding and involvement of patients and those close to them**

- Care was planned and delivered that took into account the wishes of the patients and the parents of the babies who needed special care.
- Patients were active partners in their care. They felt involved in the decision-making process and were well informed regarding their care and treatment options.
- Staff across all services were able to describe the processes they used to involve patients.
- The trust scored higher than the England average for the Patient Led Assessments (PLACE) from 2013 to 2015.

## **Emotional support**

- The trust provided support for patients and their families where required, despite some services feeling the strain of staff shortages.
- Spiritual support was available for all religious beliefs through the chaplaincy service. This included teams of volunteers trained in providing compassionate bereavement support and counselling. The parent's cultural and personal wishes were accommodated in preparing a baby after death.
- Staff were skilled and sensitive in supporting patients and those close to them during difficult and stressful periods. This was particularly evident in the care provided by the inpatient maternity and neonatal team.

## **Are services at this trust responsive?**

We found responsive required improvement because;

Excessive waiting times in antenatal clinics in some cases was more than five hours and some women were told to attend the hospital twice in one day with split appointments for bloods and a scan.

**Requires improvement**



# Summary of findings

Some patients admitted for termination of pregnancy were not able to be provided with a single room which they found emotionally upsetting.

Patients with pregnancy loss or termination of pregnancy did not have the same range of options for disposal of remains as other patients/families. The bereavement and spiritual care service stated its intention to improve this.

Although there was access to translation services for people for whom English was not their first language, some staff within surgery services perceived the use of family members to interpret for patients to be the first option.

However, we also saw;

There was a specialist midwifery team for vulnerable women which comprised of a specialist midwife in perinatal mental health, substance and alcohol misuse, teenage pregnancy, female genital mutilation, smoking cessation and high risk pregnancy.

Women with a learning disability were supported through an integrated acute and community approach.

Referral to treatment times for; non-admitted pathways within 18 weeks, incomplete pathways within 18 weeks, cancer patients waiting less than 31 days from diagnosis to first definitive treatment and percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average.

## **Service planning and delivery to meet the needs of local people**

- Services were planned to meet the diverse needs of patients living in the local area.
- There were good examples of services being planned and designed in response to patient feedback and consultation. For example, in surgery and gynaecology services the extension of the early pregnancy assessment unit (EPAU) to a seven day service was negotiated with the commissioners in response to demand from the local population and NICE guidance. This was the only unit in the region which opened seven days a week.

## **Meeting people's individual needs**

- Patients' religious and cultural needs were met through a multi-faith chaplaincy and a bereavement service for parents and those close to them who had lost their babies.

# Summary of findings

- An interpreter service was available for patients whose first language was not English and a video book was available across acute and community services in a variety of languages.
- Community maternity services provided parent education classes at local children's centres and the home birth team also ran bookable 'Meet the Homebirth Team' sessions where women asked questions and discovered the family-centred approach supported by the homebirth team.
- There was a specialist midwifery team for vulnerable women which comprised of a specialist midwife in perinatal mental health, substance and alcohol misuse, teenage pregnancy, female genital mutilation, smoking cessation and high risk pregnancy. These were all identified as areas within the health profile of the local population as key areas.
- Women with a learning disability were supported through an integrated acute and community approach. The trust used specific notes for patients with learning disabilities. These notes had larger print and were illustrated to help patients understand.
- A video recording booklet was available in each department for those who were unable to read.
- Eight parent flats were available close to the neonatal intensive care unit (NICU) for families to stay near to their baby. Staff understood that at times there were not enough flats and had to prioritise for parents who did not live close to the hospital.

## Access and flow

- Referral to treatment time for non-admitted pathways within 18 weeks between (January 2015 to December 2015) was better than the England average for all 12 months between 95% to 97%.
- We found referral to treatment time for incomplete pathways within 18 weeks between January 2015 to December 2015, the trust was consistently above the 92% standard and better than the England average for all 12 months.
- Between January 2015 to December 2015 the percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was better than the England average, with 100% of patients in all monitoring periods waiting less than 31 days, compared to the England average of 97%.
- Between the same time period the percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average for all quarters aside from one (Q3 14/15), ranging from 83% to 100%, compared to the England average of 83%.

# Summary of findings

- Excessive waiting times in antenatal clinics in some cases resulted in women being told to attend the hospital twice in one day with split appointments for bloods and a scan.
- The service sent outpatient's letters to warn them in advance of a potential two hour wait. When the waiting time in the outpatient service increased to four hours, the service changed the time on the letter to four hours. This did not address or improve access and flow for patients. We saw this as an unhelpful action by the service, which did not tackle the root of the problem.
- Bed occupancy across maternity inpatient services for 2014/15 was between 64% and 72% which was lower than the England average. However for 2015/16 the bed occupancy ranged between 72% and 82% both years were higher.
- There was good access to community maternity services and women were triaged according to their risk level. For example, women with low risk pregnancies were placed on the low risk pathway.
- Gynaecology elective surgery was undertaken every week day. Theatre utilisation was above the trust target of 80% utilisation for every month from January 2015 to December 2015, apart from July 2015 when it was 79%. A second theatre team was on call outside normal theatre hours for emergency surgery; this was shared with the midwifery service.
- Issues with the time taken to assemble the on-call team had been identified on the risk register for over five years. However, the divisional leadership team had been unable to secure agreement from the trust to take this forward and was largely unresolved.

## Learning from complaints and concerns

- Complaints were managed by the trust wide Patient Experience Team. There were examples of training actions and recommendations for staff around using training videos to improve staff communication skills, which was the second highest area of complaints. Staff were invited to appear in the training video which made it 'real to staff to see familiar colleagues.
- Between January 2015 to December 2015, there had been 86 formal complaints. All 86 complaints related to multiple subjects, with all aspects of clinical treatment featuring in 58 complaints. Poor communication and lack of information in 30, attitude of staff in 23 and appointment delays or cancellations in nine.

# Summary of findings

- The highest number of complaints related to maternity inpatients with 36 and the fewest complaints of three from maternity community services.
- Medical staff were the main profession complained about, which accounted for 59% of complaints received.
- Trust complaints policy was in place, however it did not indicate any agreed time frame to deal with complaints. We found on average it took 36 working days to deal with complaints.
- Posters were displayed through acute and community services explaining how to make a complaint. Staff discussed complaints at monthly governance meetings.

## Are services at this trust well-led?

We found well led required improvement because;

The trust had a vision 'To become the best women's and children's healthcare built around the whole family', this would be achieved through the acquisition of the trust by Birmingham Children's Hospital Foundation Trust (BCHFT).

Risk management across directorates was variable, governance and risk management structure across maternity, neonatal and surgery and gynaecology services was well imbedded. The corporate risk register did not reflect all risks across the trust, aged risks and mitigation of risks was a challenge for the trust. For example, one of the biggest challenges that faced the trust was the poor pathway in the antenatal model of care which had resulted in excessive waiting times, this was not on the risk register.

There were challenges around governance arrangements and risk management with termination of pregnancy service. For example, the new contract for the termination of pregnancy service had commenced in January 2015. At the time of the inspection, training for staff had not been formalised despite concerns expressed by staff about the need for clarity regarding actions to be taken.

However, we also saw;

Line managers in many areas were knowledgeable, responsive and accessible. Staff reported that they felt heard and valued. There were some excellent leadership role models for staff across many disciplines. However, in surgery, gynaecology and termination of pregnancy services, staff perceived there was little support from the central trust teams, such as governance or nursing. Staff felt there was little sharing of ideas, systems and processes with other services across the trust and minimal sharing of lessons learned into and out of the service.

Requires improvement



# Summary of findings

A recent introduction of E-rostering in November 2015 resulted in inflexible shift patterns and general low morale among acute and community staff. Despite this, staff across many services reported a positive, open culture and were passionate, committed and proud to work as part of the trust.

The trust was proactive and committed to securing patient feedback, and used it to inform and improve services, for example, patients' experience.

Staff received communications from managers in a variety of ways, such as emails, briefing documents and meetings. A quality and risk newsletter 'Risky Business' was circulated monthly and staff received personal feedback generated from incident reports.

## **Vision and strategy**

- Over the past 12 months, the executive board saw significant change in both executive team structure and extensive change to how the trust engaged with stakeholders. For example, the departure of the previous Chief Executive Officer, the Medical Director and the Chief Finance Officer, with a number of subsequent interim posts within the executive team.
- The trust had a vision 'To become the best women's and children's healthcare built around the whole family', this would be achieved through the acquisition of the trust by Birmingham Children's Hospital Foundation Trust (BCHFT). This vision underpinned all the trust's strategies and plans and values were well known throughout the organisation.
- All staff were aware of the trust's priorities and challenges, and understood the plans and actions needed to address them.
- The maternity service had a clear vision for the future. A draft 'model of care' overview paper and the supporting strategy document underpinned the vision.
- Despite challenges across the outpatient department staff described several plans in progress; for example, within the neonatal unit, a charity fund supported a new outside play area for children. The day assessment unit strategy included expansion of assessment times from 8am to 8pm to see more maternity patients and the aim to increase cardiac clinics by offering 60 more appointments per week for patients.

## **Governance, risk management and quality measurement**

- During the year, the Board has undertaken a periodic Well-Led Review, in line with Monitor's requirements. The review was undertaken by an external consultancy advisory service and provided an independent review of the trusts' governance arrangements in March 2016, prior to its acquisition by (BCHFT).

# Summary of findings

- Previously, the trust were heavily focused on the development of Project Vita which the Board agreed to progress in December 2014. However, this project was eventually stopped as Project Vita was not financially viable.
- Risk management across directorates was variable. Governance and risk management structure across maternity, neonatal and surgery and gynaecology services were well imbedded. The framework for governance within gynaecology had been improved during 2015/16 to make it more inclusive and improve communication within the service. The governance structure across these areas ensured performance was monitored, results discussed and actions identified to bring about improvements. The risk strategy for these areas set out clear guidance for the reporting and monitoring of risk.
- The Board was largely aware of the current status of the effectiveness of governance arrangements at the trust. They were aware of the need for further development across its services.
- We found the (BAF) which forms part of the NHS England risk management strategy and policy and is the for identification and management of strategic risks required further development. Three key risks were identified; staffing, finance and flow, linked specifically to the antenatal pathway. We were not assured that the BAF was clear who had responsibility and that risks were fully identified, understood and managed appropriately.
- There were 47 risks on the corporate risk register, 18 related to pathology and genetics which we did not inspect, as we do not have the regulatory remit to do so. The remaining 29 risks included all directorates, 37 were classed as high risks and 10 were classed as extreme risks.
- The corporate risk register did not reflect all risks across the trust and was not fully aligned to the Board Assurance Framework (BAF). Aged risks and mitigation of risks was a challenge for the trust. For example, one of the biggest challenges that faced the trust was the poor pathway in the antenatal model of care which had resulted in excessive waiting times, this was not on the risk register. The trust had commenced a review of the antenatal pathway, however there were no definitive timescales for completion within their action plan.
- There were challenges around governance arrangements and risk management with termination of pregnancy service. For example, the new contract for the termination of pregnancy service had commenced in January 2015. At the time of the inspection in April 2016 training for staff had not been

# Summary of findings

formalised despite concerns expressed by staff about the need for clarity regarding actions to be taken. There had been two reported incidents in February 2016, the RCA's recommended written guidance for staff and a comprehensive training package. However, guidance for staff was limited and there had been no further training.

## Leadership of the trust

- Over the past 12 months, the executive board saw significant change in both executive team structure and extensive change to how the trust engaged with stakeholders. For example, the trust has seen the departure of the previous Chief Executive Officer, the Medical Director and the Chief Finance Officer, with a number of subsequent interim posts within the executive team. The recent move to work towards a single organisation with BCHFT meant trust leadership was in a state of considerable change. The CEO of BCHFT had taken over the post for the trust and during their temporary absence, the deputy CEO was appointed as interim CEO. Days before the inspection the trusts' chair had resigned.
- Further work was required in succession planning with non-executive directors and strengthening the relationship and communication between the board and the council of governors which previously had been strained, this had impacted on how they communicated between ward and board.
- Despite the significant change to the board and number of interim posts the executive team had made a concerted effort to be more visible, approachable and supportive. Clinical directors and nurse managers worked closely with the executive team regarding the development and improvement of services.
- Line managers in many areas were knowledgeable, responsive and accessible. Staff reported that they felt heard and valued. There were some excellent leadership role models for staff across many disciplines.
- However, in surgery, gynaecology and termination of pregnancy services staff perceived there was little support from the central trust teams, such as governance or nursing. During the junior doctors strike staff complained of being unsupported practically with medical shifts and experienced difficulty gleaning information from the human resources department with shift rotas.

# Summary of findings

- Staff in Surgery and Gynaecology services felt there was little sharing of ideas, systems and processes with other services across the trust and minimal sharing of lessons learned into and out of the service.
- A recent introduction of E-rostering in November 2015 resulted in inflexible shift patterns and general low morale among acute and community staff.
- The trust scored worse than expected for 'induction' in the GMC national Training Scheme 2015, with all other areas within expectations.
- We provided feedback to the trust on the final day of the inspection this included areas of good and excellent care and 13 areas for improvement. Within days after the inspection we received written assurance that work had begun to address the concerns raised across all acute and community services.

## **Culture within the trust**

- Staff across many services reported a positive, open culture and were passionate, committed and proud to work as part of the trust. Across many services, particularly inpatient maternity and neonatal services we saw staff worked with a demanding caseload, however staff demonstrated they were genuinely happy when providing care to women and their babies.
- However, many clinical staff felt the acquisition process by BCHFT had been rapid and staff had not been given enough time or opportunity to engage with the executive team members. Staff described the acquisition process as a 'done deal'.
- Throughout our discussions with staff and local and divisional leaders we heard that midwifery services were given priority over gynaecology services, whether this was in relation to resources or clinical priorities. Leaders felt "held back" by a lack of resources and by having to share resources with midwifery. Staff felt frustrated by the "hoops they had to go through" to develop the service or obtain funding. A lack of resilience within the service was frequently mentioned as an issue.
- Ward staff that cared for patients who had undergone complex abortion told us they felt insufficiently supported by leaders to implement what was for some of them, a challenging and sometimes emotionally distressing new service pathway.
- Low morale was evident in community teams regarding isolated allegations of discrimination from staff had not been managed effectively by senior community leaders. Senior leaders had not responded quickly to concerns raised.
- From June 2015 to May 2016 the trusts sickness levels were generally higher than the England average.

# Summary of findings

- Staff were appropriately supported and trained to meet the requirements of Duty of Candour for women and their babies and gave examples of how service leaders provided this.

## **Fit and Proper Persons**

- The trust had prepared to meet the requirements of the Fit and Proper Persons regulation (FPPR). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust policy on pre-employment checks covered criminal record, financial background, identity, right to work, employment history, professional registration and qualification checks.
- It was part of the trust's approach to conduct a check with any and all relevant professional bodies, and to undertake due diligence checks for senior appointments.
- We looked at the personal files of three executive directors and three non-executive directors from a range of substantive and recent posts. The criteria for Fit and Proper Person requirements had been met with all six staff.

## **Public engagement**

- The trust was proactive and committed to securing patient feedback, and used it to inform and improve patients' experience for example, the Family and Patient Advisory (FPA) group met quarterly and the Urogynae Patient group (UP) met monthly to listen to patients experiences. We saw examples of how this improved practice. For example, parents who had submitted a complaint about poor care and staff attitude were present at the FPA and provided advice how parents would like to be treated. The UP group told us they had suggested that decaffeinated coffee should be offered to all patients and families as a healthier option, this had been adopted throughout the hospital.
- Ward staff routinely engaged with patients and those close to them to seek their views about their experiences at the trust.
- Staff were positive about the work of the Patient Experience team and we found a number of good practice schemes in place such as: the patient app.; patient feedback boards/stations; and a dedicated Patient Experience Strategy.
- During the summer of 2015, a questionnaire was sent to all women who gave birth in February 2015 (and January 2015 at smaller trusts). Responses were received from 202 patients at Birmingham Women's NHS Foundation Trust.

# Summary of findings

- In the 2015 CQC Inpatient maternity survey the trust scored 'about the same' as other trusts in all nineteen questions, which covered three areas: labour and birth, staff during labour and birth and care in hospital after the birth.

## Staff engagement

- Staff received communications from managers in a variety of ways, such as emails, briefing documents, newsletter and meetings.
- A quality and risk newsletter 'Risky Business' was circulated monthly and staff received personal feedback generated from incident reports, performance issues were taken up with the individual staff member.
- During our inspection a serious incident occurred, we observed support provided to staff following the event. Senior staff exhibited behaviour above and beyond expectation to ensure staff were supported in every way possible. All members of staff that were involved with the patient care were individually contacted to be informed of the incident. On the same day a councillor and religious support was available in the department for staff to speak to; senior staff were continuously visible and offering support in the days following the incident. Staff directly involved had a staged return to work when able to do so, this was facilitated by staff changing and senior staff providing clinical shifts.
- Across the majority of acute and community services staff reported that they felt empowered. They felt able to voice and escalate concerns. We repeatedly heard from staff at all levels that they felt engaged and involved in service development. However, a lack of preparation and engagement prior to the start of the new complex termination of pregnancy service was apparent.
- Over a year after its introduction staff continued to express concerns. Staff had been able to opt out of this service but we talked to several staff who were unhappy with the situation, including their lack of training and support. Staff talked about the distress to women and how they felt ill prepared to care for them.
- 572 staff took part in the 2015 NHS Staff Survey. The response rate was 33% which was below average for acute specialist trusts in England, and compares with a response rate of 44% in this trust in the 2014 survey. The trust had 22 negative findings in the NHS Staff Survey, two positive findings and all remaining within expectations. For example the bottom five ranking scores related to; percentage of staff satisfied with the opportunities for flexible working patterns, percentage of staff

# Summary of findings

experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months, organisation and management interest in and action on health and wellbeing, staff satisfaction with resourcing and support and recognition and value of staff by managers and the organisation.

- Senior managers were confident the 2016 staff survey would reflect a more positive view and were keen to express the 2015 staff survey was carried out more than 12 months before the CQC inspection.

## **Innovation, improvement and sustainability**

- The trust was a major obstetrics, gynaecology and neonatology research hospital and there were a wide range of ongoing research projects at the time of our inspection.
- The symptom specific triage assessment card within inpatient maternity services delivered consistency and clear targets for the triage process.
- Video books were available for women across acute and community services who did not speak or read English.
- The trust was awarded a (SDIP) grant by local commissioners to pilot a three year project to set up a Homebirth Service, one of its kind in the region.
- Funding was sought from the Local Education Training Council (LETC) to fund a two year foundation degree to enable the maternity assistants to acquire the necessary competencies to assist the midwife at home-births.
- Staff within the neonatal services introduced the routine use of pulse oximetry for all babies within 24 hours of birth or prior to discharge. This has been identified as significant in the early detection of critical congenital heart defects prior to the deterioration of the baby. The business case and rationale for testing has been shared nationally and around 20% of hospitals now routinely perform this test.
- Gynaecology services had been successful in becoming an accredited British gynaecology endoscopy (BSGE) centre for complex endometriosis. This is a regional specialist service whereby women with complex endometriosis are referred and includes medical, pain related and surgical management.
- The gynaecology outpatient department provided fast rehydration to patients seen in the hyperemesis clinic, which reduced re-admissions and overnight stays.
- The trust acknowledged that it was not financially sustainable in its current structure as an independent trust and the reliance on the imminent acquisition by BCHFT was crucial for the future sustainability of services.

# Overview of ratings

## Our ratings for Birmingham Women's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (community services)	Good	Not rated	Good	Good	Good	Good
Maternity (inpatient services)	Good	Good	Outstanding	Good	Outstanding	Outstanding
Surgery (gynaecology) and Termination of Pregnancy	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Neonatal services	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
<b>Overall</b>	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

## Our ratings for Birmingham Women's NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Overall</b>	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

# Outstanding practice and areas for improvement

## Outstanding practice

### We saw several areas of outstanding practice including:

- The symptom specific triage assessment card within inpatient maternity services delivered consistency and clear targets for the triage process.
- Video books were available for women across acute and community services who did not speak or read English.
- The trust was awarded a (SDIP) grant by local commissioners to pilot a three year project to set up a Homebirth Service, one of its kind in the region.
- Funding was sought from the Local Education Training Council (LETC) to fund a two year foundation degree to enable the maternity assistants to acquire the necessary competencies to assist the midwife at home-births.
- Staff within the neonatal services introduced the routine use of pulse oximetry for all babies within 24 hours of birth or prior to discharge. This has been identified as significant in the early detection of critical congenital heart defects prior to the deterioration of the baby. The business case and rationale for testing has been shared nationally and around 20% of hospitals now routinely perform this test.
- Gynaecology services had been successful in becoming an accredited British gynaecology endoscopy (BSGE) centre for complex endometriosis. This is a regional specialist service whereby women with complex endometriosis are referred and includes medical, pain related and surgical management.

## Areas for improvement

### Action the trust MUST take to improve

- Healthy Start vitamins must be stored securely in all community maternity team offices.
- Medicines are prescribed and stored in line with the trust policy, particularly intravenous fluids.
- All community midwives must attend safeguarding supervision in line with Department of Health requirements (Working Together to Safeguard Children, 2015).
- Improve the application of infection prevention and control procedures in relation to the use of personal protective clothing and equipment and hand hygiene.
- Properly maintain all equipment and medical devices.
- Provide secure storage for patient records across all clinical areas.
- Ensure the project to develop a second emergency theatre team is progressed in a timely manner.
- The trust must ensure all HSA1 certificates for termination of pregnancy are fully completed by the registered medical practitioners signing them.
- Identify, monitor and mitigate all risks relating to developing the complex abortion service pathway. In particular in respect of processes required and the impact on staff and patients of distressing elements of late gestation termination.
- Provide training to ward staff caring for complex abortion services patients in the appropriate procedures for responding to late gestation termination of pregnancy where the foetus may be indicating signs of life.
- Ensure team work between the complex abortion care service, ward teams and bereavement team and wider medical teams are strengthened to mitigate risks involved in late gestation termination of pregnancy.

# Outstanding practice and areas for improvement

- Take steps to ensure multi-disciplinary team work is improved where clinicians from other trusts are contributing the care of patients.
- Clarify the method clinician's should use to establish consent to termination of pregnancy from adult patients with learning disabilities.
- Ensure that the data collected for the Neonatal Audit Programme (NNAP) reflects the care given within the unit.
- Ensure staff receive mental capacity training in line with trust guidance.
- Implement a system to assess, monitor and improve the waiting times across clinics in the outpatients and diagnostic departments.
- Mitigate the risks relating to the health, safety and welfare of service users by regularly reviewing the risk register and include a timescale in completing any risks identified.
- Reduce the waiting times in diagnostics department by having sufficient numbers of qualified staff
- Provide community maternity staff with secure facilities and guidance to retain old diaries.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 (1) (2) (a) (b) HSCA 2008 (Regulated Activities)</p> <p>The trust had not identified, monitored and mitigated some risks relating to developing the complex abortion service pathway. In particular in respect of processes required, the need to provide training to staff because of the impact on staff and patients of foetus showing signs of life in late gestation medical terminations.</p> <p>There was a systemic failure by the registered medical practitioners (RMP) to clearly indicate on some HSA 1 certificates if the patient had been 'seen/treated' by either of the two RMPs who signed the certificate. This was because a section of the form had not been properly completed.</p> <p>This meant the trust had not captured through audit the risk to breach of its condition of registration of Termination of pregnancy services under the Health and Social Care Act 2008.</p>
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>You are failing to comply with Regulation 12 (2) (e), (g), (h) HSCA 2008 (Regulated Activities)</p> <p>Medicines including intravenous fluids were not stored securely</p>

This section is primarily information for the provider

## Requirement notices

Staff were not consistently adhering to infection prevention and control procedures in relation to the use of personal protective clothing and equipment and hand hygiene.

Equipment such as beds and infusion pumps had not been subject to regular servicing and electrical safety checks.

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1) (2) (a) (b)

The trust had not identified, monitored and mitigated risks relating to the long waiting times across clinics in the outpatients and diagnostics department and this was not included on the corporate risk register.

### Regulated activity

Termination of pregnancies

### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11 (4)

The service had no established pathway in place for addressing consent to treatment for women with a learning disability.