

# Birmingham Children's Hospital NHS Foundation Trust

## Quality Report

Steelhouse Lane  
Birmingham  
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Date of inspection visit: 17-19 May 2016,  
Unannounced 26 May 2016  
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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

Outstanding 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Outstanding 

Are services at this trust caring?

Outstanding 

Are services at this trust responsive?

Outstanding 

Are services at this trust well-led?

Good 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We conducted this inspection from the 17-20 May 2016. We returned to the hospital for an unannounced to see the hospital services outside of core business hours.

This is a specialist trust and we made a public commitment to inspect these before June 2016. We held no other intelligence to have raised the risk to require us to inspect before this date.

Please note when we refer to Paediatric intensive care unit (PICU) we are describing to Critical care for children and young people.

We conducted this inspection under our comprehensive methodology, giving the trust notice of our inspection. This enabled us to request information prior to the inspection, review information we held about the trust and speak with stakeholders of the trust. We inspected the main site, based in the centre of Birmingham. We also inspected Forward Thinking Birmingham this is a mental health service offered to young people up to the age of 25yrs. The services offered care both in-patients at Parkview and within community hubs.

Please note the service offered under Forward Thinking Birmingham had commenced fully April 2016 just prior to our inspection. BCH (Birmingham Children's Hospital) is the lead provider of the service delivered by a consortium. The inspection findings are in separate reports.

We rated the trust 'outstanding' overall;

Our key findings were as follows:

- Staff understood how and the importance of raising incidents. Learning was shared amongst the staff group to keep improving quality. The trust had started to report excellence and sharing learning when things when well.
- Multidisciplinary team working was embedded in the trust. We observed this in action.
- The feedback from parents and children was positive, with them reporting they were treated with respect and dignity. Bereaved parents described the compassionate care they received from the staff.
- Results of surgical outcomes demonstrated the team performed better or the same as comparable services.
- We noted how responsive the trust was, for instance, they were piloting a service with the aim to reduce readmissions to the hospital, by having health visitors conduct follow-up calls to patients who had been discharged from ED.
- As the trust served patients and parents from outside of the Birmingham environs, parents were able to use nearby accommodation free of charge. This allowed them the opportunity to stay near by their child whilst they were receiving treatment. They were also able to seek support from other families using the accommodation.
- All cancer referrals met the treatment targets, and 100% of all children were seen within six weeks of referral.
- Safer staffing tool demonstrated there was enough nursing staff to meet patients' needs supplemented by bank staff. Staffing sickness rates were below the England average.
- The trust had a strategy in place to ensure it met its vision. Systems were in place to ensure the board were aware of any risks that could prevent it from meeting the vision.
- Staff were aware of the values and were assessed against them as part of the appraisal process.
- The leadership was well respected amongst the staff group and were effective, with succession planning in place and a board development programme.
- The culture was one of support of each other, staff referred to 'Team BCH', and using opportunities to listen to patients carers and visitors.
- Seven never events had occurred in surgery. This had resulted in the theatre team being investigated internally to try to identify a pattern and areas for improvement. The trust had commissioned an external company to help them identify areas of improvement. A theatre task force was in place to drive the momentum.
- There had been outbreaks of reportable infections, and we saw that improvements were needed regarding hand hygiene in neonatal services. However, we did find most areas to be visibly clean.

# Summary of findings

- Consultant staffing levels in neonatal did not meet the best practice guidelines. There was a vacancy rate of 26% in child and adolescent mental health services (CAMHS).
- We saw there were a lack of up to date care plans in place for (CAMHS) patients and a lack of outcome data for neonatal services.
- PLACE scores returned demonstrated that patients were not fully satisfied with the food. The trust had done work to improve the food with the support of dieticians and the introduced defined meal times. This included feedback place mats and music for example.
- PICANET data (2014) demonstrated that standardised mortality ratios were within expected range.
- Transition services demonstrated a service which was actively supporting young people to move into adult services. Services were offered both in and out of the hospital, and the multidisciplinary team worked in a cohesive fashion such as joint clinics.
- End of life core service supported children and young people and their families during palliative care and at the end of their life. Services were responsive, with referrals accepted within 24 hours. Urgent discharges were achieved within 24hrs so children and young people could die where they requested.

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

We saw several areas of outstanding practice including:

- Within medical care, we saw outstanding use of storytelling therapists to help with children's emotions, anxiety and distress during their stay in hospital, and to help to explain treatment processes to them. Following a session of storytelling therapy, one parent reported their child had not asked for their usual pain relief overnight.
- On the PICU, a safety huddle (a safety briefing meeting) was held three times throughout the day to review patients and the PICU patient flow. An additional safety huddle was held at 4.30pm during the inspection, as patient demand was greater than capacity, which was attended by the Medical Director who was on call that evening. This was outstanding practice with team involvement for safety.
- The trust has implemented a Rare Diseases Strategy, which will deliver an innovative approach for children who due to their rare or undiagnosed condition would be required to attend multiple outpatient appointments with a variety of specialities. The Rare Disease Centre will enable all clinicians involved in the care of the child to be present to provide a holistic approach in one appointment.

Importantly, the trust must:

- The trust must take action to ensure that learning from serious incidents involving neonates ward are shared consistently across the trust. Review governance processes to ensure neonatal services assess, monitor and mitigate risks to all neonates across the trust. This should include reviewing the neonatal governance structure and morbidity and mortality meetings.
- Radiology must ensure that a radiologist is always available for advice and for protocolling CT and MRI examinations.
- Within CAMHS community, the trust must ensure there are sufficient numbers of skilled and qualified staff to provide an effective service.

Please note more outstanding practice and 'must' and 'should' actions can be found at the end of the report.

**Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Background to Birmingham Children's Hospital NHS Foundation Trust

The Birmingham Children's Hospital is over 150 years old, services have been provided from Steelhouse Lane since 1862.

Birmingham Children's Hospital is a specialist paediatric centre, offering care to young patients from Birmingham, the West Midlands and beyond.

The trust employs 3,700 people and provides a range of specialist services, including the treatment of the complex heart conditions, chronic liver and kidney disease, cancer, serious burns, epilepsy, neurology and cystic fibrosis. There are also 11 nationally commissioned services.

There are 378 beds, including a 31 bedded intensive care unit, the largest in the UK. The trust has an £251m annual income and 270,600 patient visits each year

Birmingham has a higher proportion of ethnic minority groups than the England average. The largest minority group is Asian/Asian British ethnicity (26.6% of the population compared to an England average of 7.7%). The second largest minority group is Black/Black British (9% of the population compared to an England average of 3.5%).

Birmingham local authority district ranked seventh out of 326 local authorities in the 2015 indices of multiple deprivation, making it one of the most deprived areas in the country.

Infant mortality rates and obesity in children are worse than the England average.

The trust was last inspected by CQC in November 2013 and was rated as 'compliant'.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Michael Anderson, Consultant, Chelsea and Westminster Hospital NHS Foundation Trust

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

The team included CQC inspectors and a variety of specialists: Paediatric A&E Consultant/Nurse, A&E Nurse, Paediatricians, Paediatric Nurses, Paediatric Surgeons Paediatric Critical Care Doctor, Paediatric Critical Care Nurse, Paediatric Nurse – Neonatology, Consultant Neonatologist, CAMHS Doctor, CAMHS Nurse, CAMHS Psychologist, and Transition Nurse.

## How we carried out this inspection

We inspected this service as part of the comprehensive inspection programme and visited the hospital on 17, 18 and 19 May 2016. We also visited unannounced on 26 May 2016.

We met with the trust executive team and ward managers, service leaders and clinical staff of all grades. We observed how people were being cared for, reviewed treatment records and spoke with 156 people who use

the service, carers and / or family members, over 500 staff and reviewed information given to us by the provider we looked at 216 personal care or treatment records of people who use the service.

During our visits to the trust we held eight planned focus groups to allow staff to share their views with the inspection team. These included all the professional clinical and non-clinical staff. Through these groups and during the inspection we spoke to over 200 members of staff.

# Summary of findings

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

The Friends and Family test results for the trust showed that patients and their families were happy with the care and treatment provided to them. For the period May 2015

to January 2016, the average percentage of respondents who would recommend the trust was 95%. This was in line with the England average and above the average for other children's hospitals.

## Facts and data about this trust

Birmingham Children's Hospital provides children's health services for young patients from Birmingham, the West Midlands and beyond. There are 378 beds, including a 31-bedded intensive care unit, the largest in the UK. The hospital has 13 operating theatres with 270,600 patient visits each year.

As at June 2015, the trust employed around 3,700 staff including 419 medical staff and 1,161 nursing staff.

Over 270,600 patients visit the hospital each year, including over 53,000 Emergency Department patients, 175,000 outpatients and approximately 44,000 inpatient admissions.

For the period 2014/15, the trust's revenue was just under £4.3 million and had a deficit of just over £23,000.

The trust provides 34 different specialties (including liver transplant surgery, cardiac surgery, burns, major trauma, craniofacial surgery, blood and marrow transplantation, specialised respiratory and dermatology, neurology, cystic fibrosis, Child and Adolescent Mental Health Services).

# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p><b>Summary:</b></p> <p>We have rated this trust as 'Requires Improvement' for safe, this is because:</p> <ul style="list-style-type: none"><li>• Not all staff were able to demonstrate they fully understood their responsibilities under the Duty of Candour and the trust processes in place did not reflect the full requirements of the regulations.</li><li>• There had been seven never events at the trust in the 12 months prior to our inspection.</li><li>• We saw examples of poor hand hygiene procedures in neonatal services.</li><li>• The neonatal services did not have 24-hour consultant access, which does not reflect recognised national guidelines.</li></ul> <p>However, we also saw that:</p> <ul style="list-style-type: none"><li>• Staff know how to report incidents and were actively encouraged and supported to do so.</li><li>• Nurse staffing levels in most areas reflected planned levels and were regularly reviewed.</li></ul> <p><b>Duty of Candour</b></p> <ul style="list-style-type: none"><li>• Since November 2014, 'Duty of Candour' has put a regulatory duty on providers of health and social care services to be open and transparent. It requires them to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.</li><li>• Nursing staff we spoke with were aware of the need to be open and honest with patients and make apologies, however the majority we spoke to across the trust did not fully understand at what level of harm this became a legal requirement. Staff and management were able to describe duty of candour, but did not fully demonstrate that all parts were fully undertaken and what the triggers would be for when this would come into effect.</li><li>• We reviewed nine reported incidents and found that Duty of Candour applied to six of the incidents. The trust sent four letters of apology to families and two families declined a letter. The duty of candour regulation states, "The notification must</li></ul>	<p><b>Requires improvement</b> </p>

# Summary of findings

be followed by a written notification given or sent to the relevant person.” During interview, senior leaders at the trust acknowledged that aspects of the process for Duty of Candour needed to be improved.

- Following the inspection during engagement meetings, the trust have informed us they have improved their processes regarding duty of candour.

## Safeguarding

- The trust had clear procedures to aid staff in managing potential safeguarding incidents including a clear pathway for notifying local authorities.
- National guidance sets out the required training and competency in Safeguarding for staff working with children and young people. This states that all staff working in healthcare should be trained to level 1, Level 2 is for non-clinical and clinical staff who have some degree of contact with children and clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should all be trained to Level 3.
- Child protection training was part of the trust’s mandatory training strategy at core and role specific level. It was based on training needs analysis, outlining the different levels of training available and defined which staff groups were expected to complete each level, as per national guidance. All levels of child protection training required staff to undertake a 3-yearly refresh.
- Data provided by the trust showed that in May 2016, 99.3% of staff had completed safeguarding level 1 training, 92.8% of staff had completed level 2 and 90.6% had completed level 3. This was against a trust target of 95%.
- All staff who spoken with the inspection team had a good understanding of their role and responsibilities and were aware of the policies and procedures to safeguard children. Staff were aware of the safeguarding leads within the hospital and knew how to access the team for support.
- A hospital-wide child protection and safeguarding team (CPS) provided safeguarding advice, support, guidance and training for staff.
- The trust displayed safeguarding children posters and leaflets explaining what to do about reporting and recognising abuse.

## Incidents

- National reporting and learning system (NRLS) data showed the trust reported 3316 incidents between March 2015 and February 2016. Of these, 98% resulted in no or low harm.

# Summary of findings

- The trust had a lower incident rate per 1000 admissions compared to other specialist trusts.
- There had been seven never events and one serious incident (very serious, wholly preventable patient safety incidents that should not occur if the relevant preventative measures had been put in place) reported between March 2015 and February 2016. These were two wrong site surgery incidents, three retained foreign objects and two wrong implant or prosthesis.
- BCH responded to these never events by commissioning an external review by Deloitte. Emergency meetings were held to discuss the human factors issues relating to these events.
- We saw evidence of robust investigations and actions following these never events. For example, with regard to the incident concerning a retained foreign object, the trust investigated and found the case highlighted the variable way that different theatres complete sign-out and the way in which these different routines arise from and reinforce a poor culture of sign-out. Following the investigations, a theatres task force was set up, consisting of a number of Executive and Operational Leads who were driving improvements to ensure that they had consistent compliance with all elements of the WHO checking procedure. This work includes routine auditing of the quality with which they complete the WHO checking process.
- At the time of our inspection, the trust had commissioned an external review of the 'never events', and introduced additional guidance for staff. Staff showed us how they accessed the electronic incident reporting system and all staff had access. Positive reporting was encouraged to promote patient safety
- Staff told us incident reporting was actively encouraged in the hospital. All staff we asked knew how to access the incident reporting system, and were able to give us examples of incidents they or colleagues had reported and the learning outcomes from their investigation.
- No serious incidents were reported involving neonates between May 2015 and April 2016. During our inspection, we identified two incidents that were not categorised as serious incidents that should have been. These incidents were not investigated fully to understand how the incident occurred and learning did not occur.
- The trust used a 'Children's Safety Thermometer' which measured commonly occurring harms in children and young people's services. The children's patient safety thermometer measures commonly occurring harms in children and young

# Summary of findings

people's services. The survey takes place on one day each month. 'Harm free' care is defined as not having any of the four common harms; deterioration, extravasation, pain and skin integrity (includes pressure ulcers).

- The survey showed that the proportion of patients receiving harm-free care remained similar over time and was broadly in line with the median value for other Children's hospitals, which was 85.2%.
- Survey results for the period March 2015 to February 2016, showed the proportion of patients with pressure ulcers, moisture lesions and pain varied over the twelve-month period. Scores for deterioration and pain was slightly above the median value for that period, whilst the proportion of patients with extravasation (the process by which any liquid accidentally leaks into the surrounding tissue) was better than the median value.
- Learning from excellent practice was undertaken within the trust. Staff completed IR2 forms to report good practice. These were intended to achieve the same level of learning and improvement as from incidents of harm. It was being led in PICU and learning was being shared amongst the wider hospital staff. The trust wanted it to spread organically around the trust.

## Infection prevention and control

- The trust reported no MRSA bacteraemia from September 2015 to February 2016. There were two cases of Clostridium difficile (C difficile) infections (October and December 2015). There were eight cases of Methicillin Sensitive Staphylococcus Aureus (MSSA). In addition, there were 15 cases of E-Coli.
- We saw in all but one area of the trust staff regularly washed their hands and used hand gel between patients. The trust's 'arms bare below the elbow' policy was adhered to by staff.
- Monthly ward audits were carried out on infection control and cleanliness. A ward manager told us they were given protected time to complete these audits. Data provided by the trust showed February 2016, all areas were fully compliant with hand hygiene with the exception of ED, which achieved 91%.
- On the neonatal surgical ward (NSW), there was a sign on entrance to the ward to use hand gel on entrance and exit to the ward. During observation at the entrance to the ward, we saw 10 members of staff entering the ward without using the hand gel during a 10-minute period. These staff members included nurses, doctors and managers. Following the

# Summary of findings

inspection, the trust carried out hand hygiene audits for the subsequent five working days and introduced daily cot-side cleaning checklists and provided staff with pocket sized hand gels.

## Assessing and responding to patient risk

- The service used a tool to recognise the deteriorating patient, via paediatric early warning score. The service undertook audit to ensure that escalation took place appropriately.
- PACE staff supported clinical staff when patients PEWS demonstrated that escalation was required or if staff were concerned about a patient no despite their score not triggering.
- Where children needed transport to or from the PICU the trust supplied an ambulance retrieval service where clinicians from PICU supported children during the journey from one facility to another. They also offered a remote support to other clinicians regarding a deteriorating child.

## Medicines

- We found that in some areas such as neonatal surgical ward locked medications were stored in small rooms with no doors, which meant they could not be locked. We saw that due to the size of the rooms the temperature was difficult to control. The trust sent us documents which demonstrated that risk assessments had been undertaken to ensure all mitigation was in place. Our pharmacist reviewed the documents and confirmed this was a reasonable response to the risks.
- At Parkview we saw that medicines management was well adhered to, patients received their medications as prescribed.

## Mandatory training

- Mandatory training compliance rate was set at 95% which was a high compliance target. We saw that in many areas this target was met and exceeded but not in all.
- Staff had access to mandatory training. Subjects included Manual Handling Practical Load 79% Basic Life Support 84%, and conflict resolution 98.4% compliance.
- The trust target was 95%; documents supplied by the trust demonstrated that at February 2015 the compliance rate was 86.4%. The highest compliance rate outside of safeguarding was infection prevention and control level one 98.5%. The lowest was Role Essential Medicines Management at 74%.

## Staffing

# Summary of findings

- The trust had a higher proportion of consultants and registrars than the England average but a lower proportion of middle and junior grade doctors.
- Staff sickness rates were consistently below the England average January 2012- 2016.
- The trust used its own bank staff (staff on standby) to cover unexpected staff absence such as sickness. Agency staff received induction to ensure they were competent and patients received care from appropriately trained staff.
- The ED had six full time consultants providing department cover from 0800 to 23.00 Monday to Friday and 10.30 to 19.30 on Saturday and Sunday. Overnight consultant cover was an 'on call' system. Consultants were available within five minutes to attend in ED when required.
- Between October 2015 and April 2016, 96% of planned shifts for registered nurses and 87% of care support worker shifts had been covered
- Neonatologists are paediatricians who specialise in the care of neonates who require extra care following birth. A service level agreement with Birmingham Women's Hospital was in place to provide neonatologist cover Monday to Friday, for four hours per day. There were approximately 6.5 WTE neonatologists part of the rota for this cover. Staff told us that the reality was that if work commitments at the maternity hospital were greater; there were days where the neonatologist did not physically attend but the trust did not monitor this. A neonatologist could be contacted by telephone 24 hours a day, seven days a week.
- The British Association for Perinatal Medicine provide service standards for hospitals providing neonatal care including neonatologist cover but due to BCH lacking a clear identity for neonatal care, it is unclear if they are following these standards.
- On a daily basis, more babies on the neonatal surgical ward required a high level of dependency care based on the trusts' criteria. This meant staffing levels were insufficient to provide safe care. Actual staffing levels for the month of April 2016 (29 days of data provided) showed that there were nine shifts (out of a possible 87) where there were six RNs and therefore met this standard. However, for the remaining 78 shifts, there was between three and five RNs showing that the majority of the time, staffing levels were suboptimal.
- Data from May 2016 showed that the community child and adolescent mental health services (CAMHS) had 189.5 whole time equivalent staff in post at the time of our inspection. There

# Summary of findings

were 49 vacant posts and a vacancy rate of 26%. Vacancies in the CAMHS crisis team were 73% as of May 2016. Staffing levels for this service had been placed on the trust's risk register as a concern.

- Staffing levels and skill mix were planned and implemented on medical wards. Vacant shifts were covered by bank staff that were familiar with the wards and their processes. Agency staff were not used.
- Amongst Band 5 nursing staff there was an 18-19% turnover rate. The hospital had good links with local universities and recruited students who had qualified to help with staffing shortfalls.
- At Parkview, generally staffing levels were good. When acuity levels increased, this could at times result in planned activities being cancelled. Patients made us aware of their disappointment that this happened.

## Are services at this trust effective?

### Summary:

We have rated this trust as 'outstanding' for effective, this is because:

- Care and treatment was based on nationally recognised guidelines and current best practice.
- We saw and were told about effective multi-disciplinary working across the trust.
- National audits were undertaken in medicine and demonstrated good outcomes. Surgical outcomes were also very good.
- PICU improved services and demonstrated good patient outcomes by taking part in international audits.
- The leadership had other matrix they monitored to ensure positive patient outcomes 'Nursing quality care indicator (NCQI) audits'.
- A PLACE audit had identified that food required improvement the trust had implemented changes to improve food and the overall dining experience.
- Gillick competencies were well understood and implemented by staff.

However, we also saw that:

- Care plans were not up to date in CAMHS.
- Collection of activity and outcome data was poor for both the neonatal surgical ward and for neonates overall.
- The trust did not deliver Mental Capacity Act training as part of the statutory and mandatory training package.

Outstanding



# Summary of findings

- The trust had achieved World Health Organisation 'Baby Friendly' accreditation level one this is the initial level.

## **Evidence based care and treatment**

- We saw that staff followed National Institute for Health and Care Excellence (NICE) and other professional guidelines regarding treatment. Policies and procedures were based on current best practice and national guidelines had been revised and updated regularly.
- The process to review policies regularly was overseen by the governance team with the policy review group ratifying update reviews. There was a process to ensure staff were updated when new NICE guidance was issued.
- The PICU participated in a range of local and national audits, including international benchmarking of PICUs across eight countries.
- In community CAMHS, assessments were carried out using recognised tools and care plans were developed from them. Staff did not ensure care plans were up to date, personalised, holistic and recovery oriented. We reviewed 15 care records at the North and South community hubs and four of these did not contain a care plan. The remaining 11 care records contained an initial care plan but it was recorded in only two that the young person had been given a copy and it was unclear if staff had updated the care plans following the initial choice appointment.
- We saw there was an audit plan in some but not all core services.

## **Patient outcomes**

- Collection of activity and outcome data was poor for both the neonatal surgical ward and for neonates overall. The trust could not provide data on the number of neonates cared for within the past 12 months or figures for the number and type of surgical procedures performed at the trust. The trust did implement a system to identify neonates in the hospital that commenced the week of our inspection.
- The trust told us it was proud of the good outcomes for patients and was a centre of excellence for children in neonatal services. However, there was little evidence of benchmarking.
- The trust's respiratory teams contributed to British Thoracic Society (BTS) audits on non-invasive ventilation, difficult asthma and the effectiveness of treatments.

# Summary of findings

- Nursing quality care indicator (NCQI) audits were undertaken regularly across a range of wards and service areas. These consisted of eight different indicators, which included observations, pain assessments and nutrition.
- The trust scored about the same as other trusts for seven out of eight questions in the 2014 CQC children's survey related to effectiveness.
- Surgical outcomes were good for a number of measures. For instance the results for kidney transplants. Survival rates for patients are assessed at 1 and 5 year intervals. For the 2016 report one year survival rates were calculated based on patients receiving transplants between 1 April 2011 and 31 March 2015, and five year rates included patients who had received transplants between 1 April 2007 and 31 March 2011. In both cases survival rates for Birmingham Children's Hospital were 100%. National figures for the same period were 100% and 97% respectively.

## **Nutrition and hydration.**

- In the 2014 CQC children's survey, the trust scored worse than other trusts for the question, 'Did you like the hospital food provided?' The trust implemented a new menu following the poor Patient Led Assessments of the Care Environment (PLACE) results in 2015. This provided less choice but improved nutritional quality. Menus included child-friendly pictures of the food available.
- Following the PLACE report, the board and dieticians all tasted the food and found it to be bland. Following consultation with patients, BCH had started 'musical mealtimes'. During the protected mealtime, music chosen by patients was played for the full hour. Initial patient feedback was positive and served as a reminder to staff that the mealtime was protected, including reducing the number of doctors doing ward rounds at this time.
- A member of the trust executive informed us that they had made as many changes as they could to improve the food, but had an existing contract in place, which prevented them from making all the improvements they wanted.
- Staff assessed all patients prior to admission, and monitored and recorded nutritional intake and fluid balance throughout the day. Specialist diets and referral to dieticians was also available. Age appropriate nutrition monitoring tools in line with The British Association for Parenteral and Enteral Nutrition (BAPEN) guidance were used.
- Although data demonstrated the trust exceeded national breastfeeding rates for sustained breastfeeding, they were

# Summary of findings

'Baby Friendly' accredited to level one. Level one is the minimum standard that is across many hospitals. The UK Baby Friendly Initiative is a global accreditation programme of UNICEF and the World Health Organisation, to support breastfeeding and parent-infant relationships by working with public services to improve standards of care based on a set of interlinking evidence-based standards. Services must meet the required standards to gain 'Baby Friendly' status accreditation. However, it was noted that few specialist children's hospitals hold this accreditation in the country.

## Multidisciplinary working

- We saw evidence of effective multidisciplinary team working.
- We saw medical and nursing staff worked well with other specialities to provide effective care to children and young people.
- Staff from all wards we visited, told us teamwork was good and colleagues were supportive. Staff referred to themselves as 'Team BCH' and this was notable because it was not limited to the nursing and medical staff.
- BCH introduced safety huddles across some wards to reduce the occurrence of serious preventable harm through improved communication, shared care planning and coordination of patient care.
- Staff told us that the relationship between the neonatologists from the local maternity hospital could be better and a senior manager told us that NSW does not engage with the neonatologists.
- Surgical paediatricians and the neonatologists did not meet to discuss care of neonates despite the recommendation by the West Midlands Quality Review Service WMQRS 2016 review.
- Shortly after the inspection, the trust made us aware that they had improved the review frequency and contact of staff with the neonatologist.
- Nursing staff of NSW told us they felt they had a good working relationship with surgeons and felt able to challenge them if required.
- The hospital's discharge co-ordinator had built up relationships with external agencies who were involved with on-going care for patients after they left the hospital. They worked with mental health teams, health visitors, school nurses, local authorities, clinical commissioning groups and the private sector as required.

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

# Summary of findings

- We observed staff obtaining verbal consent from patients and families across the trust, some nurses commented that they felt the discussion and information provided to parents from doctors to enable them to give informed consent for surgical procedures was good.
- Staff were unaware of any arrangements or guidance if there were concerns regarding parental capacity to provide consent for their babies. We could not find any guidance for staff regarding this in any of the trust policies or procedures and the trust confirmed there was none. Knowledge and understanding of parental capacity to give consent was lacking.
- The Mental Capacity Act would apply only to children and young people over the age of 16. There was no record that any young person had, or had required, a best interest's assessment.
- The trust did not deliver Mental Capacity Act training as part of the statutory and mandatory training package. The trust told us that training in the Mental Capacity Act and Deprivation of Liberty Safeguards had been provided to senior managers and would be cascaded to their staff. Figures for how effective this had been were not available at the time of our inspection.
- The trust dispensed its responsibilities well for people under the Mental Health Act.

## Are services at this trust caring?

### Summary:

We have rated the trust as Outstanding for caring, this is because:

- Feedback from parents about the care they received was consistently excellent.
- Patients and their families were treated consistently with high levels of respect, dignity and compassion.
- Children and parents were communicated with in a way that they could understand and enabled them to be involved with their care
- Bereaved parents were given genuine, compassionate care with clear emotional support if a child died.

### Compassionate care

- Children observed during our inspection were consistently treated with compassion, dignity, and respect.
- Children and their families spoke very highly of the staff within all areas of the hospital and appreciated their caring, responsive and compassionate attitude.

Outstanding



# Summary of findings

- We spoke with 30 parents and carers on the medical wards and, all of them told us the care their child received was “brilliant” or “excellent”. We spoke with a further 18 parents in the PICU who all confirmed that nurses were caring, calm, compassionate and sensitive with positive interactions observed between staff and children and young people across the services.
- We observed a staff member in main outpatient department display strong and supportive care. The staff member, who was working in a different outpatient clinic, recognised that a child waiting for their appointment was becoming distressed by the noise in the main outpatients waiting area. The staff member moved the child and their parents to another waiting area which was soundproofed and liaised with the clinic that the child was waiting to be seen by, in order that they could be collected from the quiet waiting area when they were due to be seen. This significantly reduced the child’s distress.
- During the inspection, we were made aware of how staff went out of their way to support both children and families. A child had lost its soft toy and it was thought it had gone into the laundry, the parent was helped into protective clothing and helped by staff to locate the toy amongst the used laundry.
- In the Friends and Family Test (May 15 to Jan 16) the trust scored better than the England average for six out of the nine months but the trust’s scores decreased below the England average between Sep’15 and Nov’15. However, the trust performed below the children’s trust average on only one occasion.

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

- Parents and carers of children on all the wards and units we visited told us doctors and nurses kept them informed about what was happening with their child’s care and discussed their children’s treatment options, medication and nutritional needs with them.
- Parents felt involved and informed with children telling us of examples when staff communicated well with them.
- Innovative interactions between staff and children were observed on the wards and PICU. Children and their parents were encouraged to ask questions and were provided with emotional support from a range of professionals.
- When communicating with children, staff used language that was jargon free and easy to understand, using play, toys and nursery rhymes to maintain engagement. One patient advised us that staff used words they could understand.

# Summary of findings

- The palliative care team had arranged for a specialist storytelling therapist to help a child who was frightened and anxious about their treatment. In the days following the therapy session, staff said the child was calmer and in a better mood, and had not required as much pain relief as they had needed before the therapy.
- The trust scored similarly to other trusts for 35 out of 36 questions in the 2014 CQC children's survey relating to caring.

## Emotional support

- Specialist liaison staff provided emotional support to patients and their relatives before operations.
- Clinical nurse specialists supported ward staff by providing additional emotional support to children and families within the different specialities.
- Every year, the trust held a memorial service at St Chad's Cathedral in Birmingham and a memorial walk and picnic at the National Memorial Arboretum in Alrewas, for bereaved families and carers of children who had been treated at the hospital. These events were facilitated by the hospital's chaplaincy department and allowed families in similar situations to exchange stories and form informal support networks for each other.

## Are services at this trust responsive?

### Summary:

We rated the trust overall outstanding for responsive because;

- The hospital was outward facing in identifying opportunities to develop the service further, these included initiatives such as the young person's advisory group.
- Health visitors were involved in a pilot scheme to follow-up ED patients. One of the expected outcomes was to help with admission avoidance.
- Children living with a learning disability were well supported by a learning disability team. Staff appeared to use the LD passports well to support patients.
- Parents of children using the hospital had the opportunity to stay at the nearby Ronald Macdonald accommodation. This allowed them some time to access support from other parents in similar situations.
- Transition services offered different opportunities to help prepare young people to transfer to adult services.

Outstanding



# Summary of findings

- Multi faith publications had been produced by the palliative care team to support families whose child had an incurable condition.
- No patients waited more than four hours to be admitted from the time of decision to admit between Jan'15 and Jan'16.
- 100% of children referred to the hospital were seen within six weeks. Oncology met all the treatment targets also.
- Complaints were responded to sympathetically and the hospital staff were able to give examples of change of practice as a result.

However,

- Community CAMHS had waiting lists which were growing in length for patients with Attention Deficit Hyperactivity Disorder.

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

- Birmingham Children's Hospital is one of four UK specialist paediatric centres. Surgical services are available to paediatric patients from across the country. Some specialities attract national and international patients.
- There was a young persons' advisory group which was proactive in ensuring patients were involved in the development, design and delivery of services for children and young people. For instance, they took part in the recruitment process of senior staff, being part of the interview panel. It was clear their opinion was very valued.
- The service was working with the CCGs to develop transition arrangements across the trust and had action plans in place with timescales for achieving the monitoring standards set by the CCG.
- The trust was currently reviewing the Emergency Department 2015 winter plans. The trust told us that early learning from 2015 had demonstrated that some changes to the service need to be established for the 2016/17 winter period. This included re-locating a dedicated minor injury service during the peak November & December period to an existing outpatient facility.
- Forward Thinking Birmingham was a set up in response to an identified need to improve mental health services in the city. The trust as the lead provider with a specialism of children was providing the service to children and young people up to the age of 25yrs. At the time of the inspection, this service had been in operation six weeks so we were not able to assess the impact yet.

# Summary of findings

- Figures available in the public domain demonstrated that ED attendances had been rising year on year and that the trend was estimated to continue.
- We heard that a pilot scheme had been commenced working with local Health Visitors to ensure that children who had attended ED were referred for follow up. Staff told us that this was on-going and results and outcomes were not yet available. This exercise was also part of the admission avoidance process, educating parents to use other available support such as local 'walk in' centres and pharmacists.

## Meeting people's individual needs

- Staff used a 'learning disabilities passport' for any patients with learning disabilities. The passport explained the needs of each individual patient and helped staff adapt their care to minimise distress to patients.
- Wards and departments had learning disabilities champions who reviewed passports to ensure patients' needs were met and supported staff to deliver responsive care. Champions also identified newly admitted patients who were living with learning disabilities and would benefit from a passport. We saw patients attending ED with the passport.
- There were two specialist learning disability nurses available in the trust for support to patients and families when seeking advice and guidance.
- The hospital had a new unit for day case surgery patients. This enabled children to be admitted to a play unit rather than directly to a ward. The hospital found that children experienced less anxiety when going to theatre directly from this new unit.
- Ronald McDonald House provided free accommodation for parents and families of patients that were in hospital for more than three days. The house is funded by sponsorship and fund raising activities. Staff told us that there is always a waiting list for the rooms. There were 65 en-suite rooms and well-equipped communal kitchen and dining areas. There were also communal lounges for families to use. The parents we spoke with told us that the communal areas create a family feel, where they can share their 'highs and lows' with other families that understand the situations and challenges they are facing. There are house assistants on duty daily and security guards are on site from 10pm each evening. Only those with a secure pass could access the accommodation.
- There were numerous activities arranged for patients who were transitioning to adult care such as, workshops for patients living with specific diseases, residential weeks, career trips and education days.

# Summary of findings

- Written advice leaflets on various conditions and health problems were available for patients and their relatives. Leaflets were written in English and we were told these could be translated into different languages when required.
- The trust employed up to sixty language interpreters. We saw staff requesting a translator for a patient on one ward, and we were still present when the translator arrived half an hour later. The Language Line translation services was also available on request.
- A special area, called the 'Rainbow Suite', was available for bereaved families to spend time with their child. The suite provided a peaceful, comfortable environment and included a waiting room, a viewing room and bathroom facilities.
- We were shown a booklet produced by the hospital, entitled "Support for Muslim Families who have been told their child is no longer curable", which contained information and guidance specifically aimed at families from the Islamic community. The palliative care team had also published a booklet called 'Multifaith Care for Sick & Dying Children and their Families' covering the needs of a range of other religions.
- In 2005 'Improving the Life Chances of Disabled People, articulated a vision that by 2025 disabled people in Britain should have full opportunities, choices to improve their quality of life, be respected and included as equal members of society. The report states that by 2025, 'Any disabled person who wants a job, and needs support to get a job should be able to do so'. A BCH programme called Aspire supported young people in gaining skills, knowledge and confidence to enter the world of work via a range of schemes. Aspire aspired to become an advocate for young people with learning disabilities and highlight their issues locally and nationally.
- The trust scored better than other specialist trusts in all indicators in the 2014 and 2015 PLACE audits. In 2015, the trust's scores deteriorated in all areas except cleanliness but still scored better or similar to other children's trusts in all areas except facilities.
- The 2014 children's survey scored worse than other trusts for the question 'did you think there were appropriate things for your child to play with on the ward?'
- Staff had to conduct difficult conversations with relatives about their children's terminal diagnosis in inappropriate surroundings such as offices, kitchens and empty cubicles and playrooms. Magnolia House was under construction, a purpose built building, which will offer a calm and natural environment that, will support families in these emotional circumstances.

## Access and flow

# Summary of findings

- In April 2016, the percentage of patients seen or admitted within 4-hours of arrival at the emergency department (ED) was 96.5%. Between May 2015 and April 2016, the department achieve the 4-hour waiting time target in eight out of the 12 months. The department did not meet the target in November 2015 (88%), December 2015 (86.5%), February 2016 (92.5%) and March 2016 (93.1%). Where the target was not met, the department was above the England average in all instances.
- Data provided by the trust showed that in February 2016, 100% of children and young people requiring planned diagnostic tests or procedures were seen within 6 weeks of referral. This was consistently achieved by the trust.
- Oncology outpatients met all of the targets for non –admitted patients. The most current data available showed that 100% of children with suspected cancer attended outpatient appointments within 2 weeks of referral from their GP. First treatment was provided to 100% of children within 31 days of referral.
- Bed occupancy between March 2014 and November 2015 was consistently higher than the England average. Occupancy was over 95% for seven out of the eight quarters during that period.
- The trust did not effectively monitor or manage access and flow to the neonatal surgical wards. We requested data of admissions, cot occupancy, discharges, gestation at admission and number of refusals to the ward however; the trust confirmed it did not routinely collect this data. However, they had implemented a system the week of our inspection with a recording system.
- Multi-disciplinary 'Hospital operations meetings' were undertaken twice a day involving senior staff from departments throughout the hospital. Senior staff shared information about risks in relation to patient safety; for example, risks in relation to staffing levels. This meant that the trust continually monitored and allocated staff dependent on the care, treatment needs and dependencies of patients using the service. This helped to smooth the flow of patients through the hospital helping to reduce overcrowding and discharge delays and ensured patient safety.
- The surgical directorate's average length of stay between June 2015 and March 2016 were 4.6 days and 109.4 hours. Staff recorded it as being better than the England average for elective surgery and non-elective surgery.
- We found a number of elective surgeries was cancelled due to lack of critical care beds and the trust has confirmed 17% of all cases that are cancelled are cancelled on the day or day after admissions due to more serious case prioritised.

# Summary of findings

- Transition pathways were driven by the patient's health needs. Speaking with patients, parents and staff and reviewing transition pathways it was clear that strong relationships with other providers was key to the success of transition into adult care. Staff told us and we saw that patients transitioning to adult care were planned on an individual basis. Clinical transition leads and champions told us for the majority of patients, transition planning started at the age of the young person moving from primary into secondary school education.
- At Parkview we saw that they had to refuse 53 admissions (June 2015- May 2016) due to lack of bed capacity.
- Waiting lists were increasing within community CAMHS for patients with a diagnosis of Attention Deficit Hyperactivity Disorder. The number of referrals was increasing and the number of clinics being offered was not addressing this increase in demand.

## Learning from complaints and concerns

- Complaints were managed by the patient experience team and patient and liaison service (PALS.)
- A trust complaint policy was accessible to all staff via the trust intranet.
- Posters were displayed throughout the trust explaining to families how to make a complaint.
- The trust received 124 complaints between January 2015 and February 2016. Recurrent themes (January to April 2016) were delays in care, surgical complications, staff attitude, not being listened to, poor management of appointments and safeguarding.
- The trust responded appropriately to complaints. For example, a father raised concerns that his young son had been fasted for an extended period of time, without reviewing the possibility of his son being allowed something to eat. The case was shared with teams resulting in improved communication between theatres and wards. The trust developed new guidelines incorporating advice on managing admissions and times children are allowed to eat and drink prior to operations.
- The trust shared complaints widely amongst the staff including the CEO using social media to share her concerns regarding feedback on individual complaints about the service. (This was undertaken appropriately being generalised and the complainant anonymised). However, the overall process was always managed via the governance process.
- The trust had a real time feedback app, which was monitored and any complaints, which could be resolved quickly, staff attempted to do so.

# Summary of findings

## Are services at this trust well-led?

Good



### Summary:

- The trust had a strong vision and values with an associated strategy defining how it would meet them. Staff had been involved in describing the vision. Some local areas had their own vision and strategy in place which aligned with the trusts overall.
- Appraisals were linked to the values, so staff worked daily to meet and demonstrate them.
- The governance structure supported the trust to understand the risk within the organisation as a whole. They understood the risks to not achieving the vision by the regular review of the board assurance framework.
- The committee structure also supported the board to recognise areas that were performing either well or not, and be able to address those accordingly.
- The root cause analysis investigation process was formalised and robust, identifying areas of learning and disseminating that information to the relevant parties.
- The leadership was effective and well respected. There was a programme of board development and succession planning in place.
- The culture was one of openness and all the staff working closely together which they referred to a 'Team BCH'.
- Engagement with staff, patients, families and visitors was well embedded, especially the many routes available for people to feedback their opinions of the service.
- We saw many innovative practices in place; these included the 'Learning from Excellence' initiative.

However;

- The neonatal service had not undertaken all the recommendations of two external reviews. There was a neonatal 'innovation and improvement' group set up in March 2016. On receiving feedback we found that the trust executive undertook immediate actions to improve the service.

### Leadership of the trust

- The CEO and senior management team were passionate and driven to provide an excellent service for children and their families. Their enthusiasm, motivation and commitment to improve children's services within the hospital and across Birmingham were evident.
- The leadership were very responsive and made rapid plans to improve services that we highlighted required improvement.

# Summary of findings

For example, immediate plans were put in place to improve neonatal services including new leadership and a short-term, medium and long-term strategic plan produced, following our inspection feedback.

- The CEO engaged with social media to share news about the trust with the public. This was done in such a way to ensure the anonymity of the complainant. Also the official process was still managed by the governance function.
- Staff told us the senior management was visible and accessible to them.

## Vision and strategy

- The trust had a vision, 'To be the leading provider of healthcare for children and young people, giving them care and support – whatever treatment they need – in a hospital without walls'. The vision underpinned the trust's six strategic objectives that focused on their current position and what they wanted to achieve in the future.
- In 2011 in consultation with over 2,800 staff, the trust identified five values it believed should underpin all aspects of care organisation and delivery. The values were courage, respect, trust, commitment and compassion. The governors confirmed they were part of this process also.
- Within some core services, staff were able to describe the local vision and strategy. For example, ED were able to describe the plan to evaluate the service over the summer of 2016 to ensure the service will meet demand for the winter months. Staff within medicine in particular the liver service had mnemonic identifying values using the letters from the word 'Liver'.
- Within Forward Thinking Birmingham, the vision was 'To be the first city where mental health problems are not a barrier to children, young people or young adults achieving their dreams'.
- Neonatal services (except the outreach team) were not able to describe the vision and strategy for the service offered.
- Staff were able to describe the values that the trust held. Appraisals were linked to the trust values.
- Staff told us about a yearly event run by the trust called 'InTent'. Each one had a theme the January 2016 event was about all aspects of safety. This included staff feeling safe to speak up and what barriers to this may exist within the organisation. All staff had an opportunity to attend. The event took place in a marquee in a garden on site.

## Governance, risk management and quality measurement

# Summary of findings

- The trust did not use a corporate risk register but monitored risks on their board assurance framework (BAF). The risks were aligned to the strategic objectives and rated. Each risk had a mitigation and executive owner and timescales for review or resolution.
- We identified risks that were not on the BAF such as never events related to surgery and the helicopter sometimes being unable to land on or near the ED. However, during interviews of the executive and senior management team they all were able to tell us the most concerning risks to the organisation at the time of the inspection.
- The board commissioned an external review of the governance structure in 2015. We saw a number of recommendations were made. The trust demonstrated that they were working through them. We saw one related to the monitoring of actions and deadlines used as mitigation associated with the BAF. We saw a report, which was shared with the board, which identified overdue actions. They had an owner and reason for the deadline breach. This appeared to be in line with one of the recommendations of the external review.
- A governance process was in place and most risks within the organisation were recorded within the incident recording process. The governance team supported senior staff to identify incidents, which needed additional investigation. They also supported staff to identify and describe risks and mitigations in a uniform manner. The team recognised that these staff needed more education to undertake this role with less input from the governance team.
- We reviewed a number of Root Cause Analysis investigations they followed the same format and identified areas of improvement. They all included an action plan that detailed completed actions. Non-executive directors are always part of the investigation panel.
- Regular team meetings took place throughout the hospital. The meetings ensured risks and audit activity and results were discussed. Theatres closed down for half a day six times a year to ensure all member team meetings took place. The only exception was radiology who due to staffing issues could not arrange regular audit reviews of their audit activity / results.
- At the time of our inspection, the second edition of the safety casebook had been published and distributed around the trust for staff. It highlighted learning from both excellence and areas for improvement.
- Morbidity and mortality meetings took place within each department.

# Summary of findings

- There was a governance structure in place, which enabled challenge and debate and the board to be sighted on the risks to the organisation.
- Key performance indicators were monitored regularly. For example, the nurse care quality indicators had various matrixes. One executive described how the compliance of height and weight could be used as a good baseline indicator, when it falls below 90% this would trigger further investigation.
- Neonates have unique needs particularly around development, nurture and bonding, which are even more critical when they are sick or require surgery. Two external reports commissioned by the trust highlighted that the care of neonates required improvements. A neonatal 'innovation and improvement' group was set up in March 2016, to address the issues raised. We noted that several action milestones had not been achieved at the time of our inspection.
- The Chief Medical Officer had within her responsibilities safety and clinical governance; she worked very closely with the Chief Nursing Officer who had within her portfolio, quality patient experience and infection control. The safety and quality report Feb 2016 was jointly authored by the Chief Medical Officer and Chief Nursing Officer. It detailed rates of complaints, infections, mortality rates and safeguarding incidents.
- The trust had a clinical audit lead but no non-clinical audit facilitator support due to the post being made redundant. There were numerous incomplete or outstanding audits. The trust recognised the need for an audit strategy.

## Leadership progression planning

- The BCH ASPIRE programme offered opportunities such as apprenticeships, work experience and internships. Disabled children had opportunities to develop their skills and increase their chances of gaining employment.
- Board development was in place for the leadership. There was a multi-professional leadership programme in place. It covered 'team player, team maker, and leading the way.'
- Succession planning was in place. The executive team have actively identified the future leaders within the trust. Well-respected courses had been procured to support those individuals development.
- Non-executive directors and executives all received 'one to one's' with the chair and chief executive.
- Visiting physiotherapy and nursing staff offered career taster days and a range of enterprise and employability programmes.
- The trust recognised the challenge in recruiting more BME (black minority ethnic) people into posts. The recruitment

# Summary of findings

process had been reviewed and the trust's inclusivity group explored how to transfer BME applicants into appointments. BME staff that had not progressed in the previous three years were offered a career interview. This scheme was in the process of being offered to all staff at the trust. In addition, the board had completed bias training to help improve the situation. It was planned to deliver this training to middle management.

## **Culture within the trust**

- Staff mostly reported a positive, open culture and were passionate, committed and proud to work for the trust.
- We saw and were told by many staff about 'Team BCH'. This appeared to be a real culture of teamwork that included all levels of staff. Although this is a very positive organisation, one negative outcome of a team that is too close was the inability to manage poor performance. One of the senior management team admitted they could at times allow poor performance issues to continue for too long.
- Four ambassadors for cultural change were in post. These roles were based on an innovative model. 'To help empower staff to deliver an excellent service and be an ally for anyone of the frontline who is worried about raising concerns'. They supported staff in a confidential manner. There were also staff experience champions in place to support staff; this has worked well where teams are less cohesive.

## **Fit and Proper Persons**

- We reviewed a number of personnel files of our choosing, for executive and non-executive directors. We found that they met the Fit and Proper Persons regulation requirements.
- A checklist document was maintained of staff that the regulation applies to and their current compliance. We saw that that contained evidence that that the regulations were being met.

## **Public engagement**

- In conjunction with parents, BCH had developed a 'Listening to You' guide - to empower parents to speak more openly to staff about a worry or concern about their child's condition.
- Children and young people developed job descriptions and supported the recruitment for the Roald Dahl funded rare disease nurses.

# Summary of findings

- BCH had an interactive feedback mechanism for use from mobile phones. This meant that people could raise issues at the time they occurred. The trust closely monitored the feedback so that issues raised could be addressed in a timely manner.
- 'Patient Opinion', was an anonymous BCH service that posted patients' thoughts and opinions on the trust's services on a national website.
- The trust had a Facebook page where members of the public could voice their views on services received.
- Children attending the service made and designed badges ahead of our arrival for the inspection team to wear during the inspection.

## Staff engagement

- The trust had implemented a, 'Star of the month' or 'Team of the month' scheme as a way to acknowledge and thank staff/ teams for their hard work. Colleagues filled out the nomination form detailing how the nominee had demonstrated the trust's values. All nominees were invited to attend the monthly Chief Executive Briefing session where the winner received a 'Star of the Month' pin badge, trophy, certificate and featured on the Star of the Month intranet page.
- In the end of life care service, a nurse's day project was held for newly qualified nurses as an opportunity to reflect on the values of the nurse's role.
- The trust received eleven positive findings and six negative findings out of 34 indicators in the 2015 NHS staff survey. Positive findings included feeling valued, communicated with, support from managers. Negative findings included resourcing and satisfaction with the quality of work they could deliver. The response rate was 40% this was below the England average of 45%.
- Management circulated a weekly bulletin informing staff of themes and learning arising from incident reports.
- BCH held an open 'Tea' event in the patient's area as a way to engage the public where patients could discuss any issues or concerns.
- A 'Knowing BCH team' event was held last year as a way for staff members to learn more about each other.
- In 2016, the trusts announced the appointment of four new Ambassadors for Raising Concerns in order to strengthen the culture of speaking out safely and help individuals and teams

# Summary of findings

to feel safe in raising any concerns. These roles were based on the Helene Donnelley model, “To help empower staff to deliver an excellent service and be an ally for anyone on the frontline who is worried about raising concerns”.

## **Innovation, improvement and sustainability**

- Within PICU a communication system was in use to support staff on the large unit. It supported them communicate with other staff on the unit whilst not leaving a patient for instance summoning help. It was also being used with McLaren analysis of real time data to look at early warning systems.
- Staff had implemented a, ‘Placemat feedback scheme’ where children could provide written feedback on their meals.
- Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. BCH operated a system to report good practice: IRIS (Improving Resilience Inspiring Success). Excellence Reporting (ER) had been used in PICU since April 2014. Episodes of excellent practice were identified and reported online ‘IR2 forms’ by staff members. IR2 forms are incident-reporting forms where excellent practice needs to be reported. Reports were categorised in two domains: excellence category and clinical context. Individuals were notified of their ER citation via the trust governance department. Learning points were shared with the department through weekly e-bulletins and display boards. This was deemed a very innovative approach and was shared at national conferences.
- Since April 2014, IR2 reporting had increased from 12 per month to 80-90 in May 2016 demonstrating a willingness amongst staff to take on the new approach.
- BCH had launched a new alternative to the traditional backless hospital gown, which they named the ‘Dignity Giving Suit’. The trust acknowledged that visiting the operating theatre could be nerve wracking for their young patients and having to wear an ill-fitting, uncomfortable hospital gown added unnecessary discomfort. Acting on feedback from young people and families, BCH enlisted the expertise of uniform design company and developed an innovative solution, which maintained patients’ dignity while allowing quick, easy and dignified access for their procedure and follow-up care. The design was registered with patent pending and was in the process of being adapted for the adult market. BCH were expecting the, ‘Dignity giving suites’ to be showcased at hospitals across the country later this year.
- The trust developed a two-minute animation, taking inspiration from the airline industry, to empower children, young people

# Summary of findings

and families to stay safe. Safety experts and some of the trusts young people developed the animation to improve the safety information children and parents received on admission. This covered hand washing, what to do if family and friends want to visit whilst they are unwell, medication checking, extravasation (leakage of fluid) and pressure care to prevent the risk of pressure ulcers.

# Overview of ratings

## Our ratings for Birmingham Children's Hospital Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Surgery	Requires improvement	Outstanding	Good	Good	Good	Good
Critical care	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Neonatal services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Transitional services	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
End of life care	Good	Good	Outstanding	Outstanding	Good	Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Outstanding	Good	Requires improvement	Good
<b>Overall</b>	Requires improvement	Outstanding	Outstanding	Outstanding	Good	Outstanding

## Our ratings for Birmingham Children's Hospital NHS Foundation Trust

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

# Overview of ratings

## Our ratings for Mental Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall for service	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

# Outstanding practice and areas for improvement

## Outstanding practice

### Trust wide

- Excellence reporting was newly being rolled out in to all areas of the hospital, however, research and piloting had been undertaken in the PICU. The staff were raising alternative incident reports to demonstrate when things went well. The results were that learning was shared about best behaviours and procedures followed, to encourage best practice in activities.

### ED

- Every relative, carer or patient we spoke with told us that they were thankful to be seen at BCH and praised the staff for the care and attention once in the department. A few relatives told us they may be anxious about the long wait in a crowded, warm waiting area but they knew they were in safe hands, so it was worth it. They told us they felt relieved when their child had been through the triage process and they knew they would be seen.

### Medicine and End of life care

- The complex care team had planned a holiday to Disneyland and a cruise for two of their long-term ventilated patients and had arranged for carers to accompany the patients who would otherwise have been unable to go on the trips.
- We saw outstanding use of storytelling therapists to help with children's emotions, anxiety and distress during their stay in hospital, and to help to explain treatment processes to them. Following a session of storytelling therapy, one parent reported their child had not asked for their usual pain relief overnight.
- The provision of a 'party cupboard' demonstrated outstanding forethought and a genuine desire to make children's stay in the hospital as pleasant as possible.

### Surgery

- Staff went the extra mile to provide outstanding personalised care to learning disability patients. A Learning disability patient had a phobia of wearing a nametag so staff took a photograph of the patient to identify him, which staff put above his bed.

### PICU

- A safety huddle (a safety briefing meeting) is held three times throughout the day to review patients and the PICU patient flow. An additional safety huddle was held at 4.30pm during the inspection, as patient demand was greater than capacity, which was attended by the Medical Director who was on call that evening. This was outstanding practice with team involvement for safety.
- Long-term children (in hospital more than 3 months) were allocated a small team of staff to care for them who worked with the multidisciplinary team including the child's local authority. We saw strong relationship bonds between the staff and the children in their care. In addition, continuity of care developed and staff described individual staff preferences, which they had learnt from caring for the child and working with the families.
- Parents praised the PICU staff for the outstanding care and had nothing but praise for the team.
- Staff proudly informed us that the HDU had won the 'outstanding clinical team' award in December 2015.
- The introduction of the team names after kingdoms had been supported by managers following the introduction of the team makers and team player training which had increased teamwork and had led to outstanding care delivered to children, young people and families.

### Neonatal Services

- The neonatal surgical outreach team provided support, training and empowerment to staff in the local neonatal units, facilitating the right care at the right place for each surgical baby. The lead nurse was delivering a university-accredited course for nurses to gain neonatal surgical skills.

### Transition Services

- The Transitional Care Policy sets out that transition to adult services would normally take place at their sixteenth birthday (with the exception of those with a

# Outstanding practice and areas for improvement

diagnosed learning disability at 19). Or the young person was under the care of multiple consultants at the trust. If the young person had any of the above, transition could be delayed up until the age of nineteen years and regularly reviewed.

- The YPAG hosted 'The Big Discussion' was supported by the RCPCH, the National Children's Bureau and Healthwatch Birmingham which brought together local youngsters and healthcare professionals from all over the UK, to discuss important health topics.

## Outpatients Diagnostic Imaging

- We observed that clinical and non-clinical staff were skilled in engaging with children, young people and their families or carers. Engaging them and listening to their views and concerns, and taking action as appropriate.
- The trust has implemented a Rare Diseases Strategy, which will deliver an innovative approach for children who due to their rare or undiagnosed condition would be required to attend multiple outpatient appointments with a variety of specialities. The Rare Disease Centre will enable all clinicians involved in the care of the child to be present to provide a holistic approach in one appointment.

- Introduction of new easily identifiable referral forms for all research examinations, including the introduction of research protocols and guidelines available to radiology staff when arranging for a patient to have a research procedure.
- The radiology department has offered an 'express' MRI service since 2009. When patients attend their appointment they are admitted into radiology by a nurse, they are then anaesthetised, scanned, woken up, given a drink and then allowed to go home once medically fit. Patients spend a maximum of 2½ hours in radiology and this service has freed up seven beds per day. This service has won an innovation award.

## CAMHS Community

- Staff at the place of safety completed screening tools for young people at risk of sexual abuse. This demonstrated concern for arrangements for young people leaving the place of safety who had not been detained.
- Staff at the trust had developed a range of initiatives to involve young people in the planning and delivery of their care, a young persons' advisory group was in place and young people were invited to take part in the recruitment process for new staff.

## Areas for improvement

### Action the trust MUST take to improve

#### ED

- The observation unit must have staff in attendance at all times and staff must ensure that all patients have name bands in place to maintain their safety.
- The trust must review the risk register for ED to ensure all registered risks correspond with all risks and concerns in the department.

#### Medicine and End of life care

- The hospital must ensure checks on emergency trolleys are carried out daily.
- The hospital must ensure staff record times of medicine administration accurately.
- The hospital must ensure patients' paper notes are stored securely on all wards and units.

#### Neonates

- Review the categorisation of clinical incidents based upon the potential harm to ensure serious incidents are sufficiently investigated, and learning shared consistently across the trust.
- Take swift action against the recommendations of commissioned external reviews.
- Review governance processes to ensure neonatal services assess, monitor and mitigate risks to all neonates across the trust. This should include reviewing the neonatal governance structure and inclusion in morbidity and mortality meetings.
- Establish a local and national audit programme to assess and monitor care quality and performance against national standards including neonatal outcomes.
- Risk registers must reflect neonatal risks.

# Outstanding practice and areas for improvement

- Review the service level agreement for neonatologist cover in line with national guidance. Review nursing and medical cover for neonatal services in line with national guidance.
- Ensure there is a robust system in place to flag when medical equipment requires maintenance and establish clear lines of responsibility of this.
- Perform a risk assessment of the clinical care suitability of cubicle 9 on the neonatal surgical ward. Reinstate the door of the drug room on the neonatal surgical ward and ensure the room temperature is appropriately controlled for the medicines stored in that room.
- Ensure that staff are adhering to the trust's infection control policies in terms of hand sanitisation.
- Review and establish the quality in specialty training requirements for neonatal nurses.
- Identify and establish an appropriate acuity and dependency tool to ensure safe staffing levels.
- Review the missing child policy and ensure all staff are familiar with both the policy and the process.
- Establish a clear identity and strategy for neonatal services for the trust.

## Outpatients Diagnostic Imaging

- Radiology must ensure that a radiologist is always available for advice and for protocolling CT and MRI examinations.

## CAMHS Community

- Ensure there are sufficient numbers of skilled and qualified staff to provide an effective service.
- Ensure that risk assessments are updated on a regular basis and using the risk screening tool.
- Ensure that care plans are completed consistently using the care planning documentation.
- Ensure that information needed to safely manage patient care is accessible and available for staff.
- Ensure that cleaning records are maintained and that staff are able to access them.
- Ensure that equipment and facilities are available to support staff in carrying out their role.
- Ensure that consent to treatment is obtained and recorded within patient care records.
- Ensure that staff at the place of safety accurately complete records relating to the duration of use of the section 136 suite.

- Ensure that the policy for the place of safety is updated to reference the 2015 Mental Health Act Code of Practice.
- Ensure that staff receive an annual appraisal and that management supervision is provided consistently for staff.

## Action the hospital SHOULD take to improve

### ED

- The trust must review arrangements for incidents involving other emergency services to ensure working arrangements are agreed and fully understood.
- The trust should review the space for medication preparation in the resuscitation area to minimise the likelihood of medication errors.
- The trust should ensure that information regarding the trust complaints process is adequately provided.
- The trust should review the waiting areas and ensure that adequate provision is made to maintain levels of cleanliness at all times.

### Medicine and End of life care

- The hospital should improve awareness of 'Duty of Candour' among ward managers and nurses
- The hospital should ensure nurses on medicine rounds change their red 'do not disturb' aprons between patients.

### Neonates

- Develop a neonatal care trust-wide policy based on external review recommendations.
- Appoint an appropriate clinical lead to oversee neonatal service improvement.
- Establish a clear admission and discharge criteria to the neonatal surgical ward.
- Develop and implement a trust-wide definition of a neonate.
- Review ward access to both ward 9 and the neonatal surgical ward.
- The trust should consider the promotion of a learning culture across neonatal services.
- The trust should consider the involvement of staff and families in the future shaping of neonatal services.
- The trust should consider its use of the neonatal network IT system as recommended by the WMQRS review.

# Outstanding practice and areas for improvement

- Establish systems and processes to collect access and flow data for neonates admitted to the trust.
- Improve mandatory training compliance rates.
- The trust should display neonatal outcomes for staff to see.
- Review the neonatal surgical ward high dependency criteria.
- Set up regular meetings between BCH neonatal staff and SLA neonatologists.
- Explore neonatal hearing screening provision at the trust.
- The trust should consider reviewing safeguarding policies to include the impact of parental mental capacity to provide consent. Provide training to staff on mental capacity assessment.
- Assess and monitor compliance of neonatal care checklists completion
- Assess and monitor compliance of neonatal care checklists completion.
- The provider should provide training to support staff who are involved in a notifiable safety incident, in line with the duty of candour regulation.

## Transition Services

- There was no centralised approach to how information was shared with other external providers when taking over the care of young people transitioning to adult care.
- We saw a variety of information provided to patients across a range of specialities, which were produced in different formats.

## Outpatients

- The trust should ensure that there is sufficient administrative and clerical support to outpatient clinics.

- Radiology management must take steps to improve the working relationships between the staff groups working on Saturday MRI lists. Efforts should also be made to ensure that the radiographers and radiologists work as a cohesive team.

## Diagnostic Imaging

- Staff should ensure that resuscitation and anaesthetic trollies in radiology are checked on a regular basis.
- Radiology management should clarify with staff the level of safeguarding training they have received.
- Radiology management should appoint an appropriate member of staff as the radiation protection supervisor for theatres.
- Cardiac MRI images should be reported promptly.
- The trust should ensure that the out-of-hours interventional radiology service is robust.
- Radiology management should ensure that the on-call system for radiographers is in line with trust policy, especially with regard to compensatory rest and the fact that employees are not expected to make good the hours lost when called in for a prolonged period after midnight.

## CAMHS In patients

- Ensure staff are offered regular supervision and this is documented with actions taken.
- Ensure staff investigate incidents thoroughly and action plans are developed from learning.
- Ensure there are enough activities during the weekend for patients who do not leave the service.
- Ensure activities are not cancelled due to staff shortage.

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
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>Regulation 12(2)(a)(b)(c)(e)(g)(h)</b></p> <p>(a) assessing the risks to the health and safety of service users of receiving the care or treatment;</p> <p>(b) doing all that is reasonably practicable to mitigate any such risks;</p> <p>(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;</p> <p>(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;</p> <p>(g) the proper and safe management of medicines;</p> <p>(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;</p> <p>How this regulation was not being met:</p> <p><b>For Emergency Department:</b></p> <p>The observation unit did not have staff in attendance at all times. Staff did not ensure that all patients had name bands in place to maintain their safety.</p> <p><b>For Medicine and End of Life Care:</b></p> <p>The hospital did not ensure staff carried out checks on emergency trolleys each day.</p> <p>The hospital did not ensure staff accurately recorded times of medicine administration.</p> <p><b>For Neonatal services:</b></p>

## Requirement notices

The neonatal service did not ensure there was a robust system in place to flag when medical equipment required maintenance and did not establish clear lines of responsibility of this.

The neonatal service did not ensure risk assessments were conducted of the suitability of cubicle nine for clinical care on the neonatal surgical ward.

The service did not ensure the door of the drug room on the neonatal surgical ward was reinstated and the room temperature was appropriately controlled for the medicines stored in that room.

The service did not ensure staff adhered to the trust's infection control policies in terms of hand sanitisation.

The service did not review and establish the quality of specialty training requirements for neonatal nurses.

### **For Outpatients and Diagnostic Imaging:**

The radiology department did not ensure that a radiologist was always available for advice and for protocolling CT and MRI examinations.

### **For CAMHS Community:**

CAMHS Community had not ensured risk assessments were updated on a regular basis using the risk-screening tool.

CAMHS Community had not ensured that care plans were completed consistently using the care planning documentation.

CAMHS Community had not ensured that information needed to safely manage patient care was accessible and available for staff.

CAMHS Community had not ensured that cleaning records were maintained and that staff were able to access them.

CAMHS Community had not ensured that equipment and facilities were available to support staff in carrying out their role.

# Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17(2)(a, b, c)(d) i, ii)

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of

the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from

the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and

treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) maintain securely such other records as are necessary to be kept in relation to—

(i) persons employed in the carrying on of the regulated activity, and

(ii) the management of the regulated activity;

How this regulation was not being met;

**For Emergency Department:**

The trust had not reviewed the risk register for ED to ensure all registered risks corresponded with all risks and concerns in the department.

**For Medicine and End of Life Care:**

The hospital did not ensure patients' paper notes were stored securely on all wards and units.

**For Neonatal services**

The neonatal service did not review the service level agreement for neonatologist cover in line with national guidance.

The service did not review nursing and medical cover for neonatal services in line with national guidance.

This section is primarily information for the provider

## Requirement notices

The service did not review the categorisation of clinical incidents based upon the potential harm to ensure serious incidents were sufficiently investigated, and learning shared consistently across the trust.

The service did not take swift action against the recommendations of commissioned external reviews.

The service did not review governance processes to ensure neonatal services assessed, monitored and mitigated risks to all neonates across the trust. This should have included reviewing the neonatal governance structure and inclusion in morbidity and mortality meetings.

The service did not establish a local and national audit programme to assess and monitor care quality and performance against national standards including neonatal outcomes.

The service's risk register did not reflect neonatal risks.

The service had not established a clear identity and strategy for neonatal services for the trust.

The service had not reviewed the missing child policy and did not ensure all staff were familiar with both the policy and the process.

### **For CAMHS Community**

The service had not ensured that staff at the place of safety accurately completed records relating to the duration of the use of the section 136 suite.

The service had not ensured that the policy for the place of safety was updated to reference the 2015 Mental Health Act Code of Practice.

## Regulated activity

Treatment of disease, disorder or injury

## Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1)

18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

This section is primarily information for the provider

## Requirement notices

How this regulation was not being met;

### **For Neonatal Services**

The service had not identified and established an appropriate acuity and dependency tool to ensure safe staffing levels.

### **For CAMHS Community**

The service had not ensured there were sufficient numbers of skilled and qualified staff to provide an effective service.

CAMHS Community had not ensured that staff received an annual appraisal and that management supervision was provided consistently for staff.

## Regulated activity

Treatment of disease, disorder or injury

## Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

### **Regulation 11 (1)**

How this regulation was not being met;

### **For CAMHS Community**

The service did not ensure that consent to treatment was obtained and recorded in patient care records.