Birmingham Community Healthcare NHS Foundation Trust

Community health services for children and young people

Inspection report

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Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Our findings

Community health services for children and young people

Good ↑

Birmingham Community Healthcare NHS Foundation Trust provides community-based healthcare to people of all ages across Birmingham, covering a population of approximately one million people and a geographical area of 103 square miles across Birmingham, Sandwell, Dudley and Walsall. It also provides specialist rehabilitation services including regional rehabilitation services to assist people manage disabilities, and at Birmingham dental hospital for people of the wider West Midlands region, including Warwickshire, Staffordshire, Worcestershire, Shropshire and Herefordshire.

The trust provides services in people's homes, primary care premises and community inpatient facilities. The trust provides care for people in over 300 locations and approximately 100 of these are managed by the trust.

The trust provides;

• Adult community services – including community nursing and therapy services, Early Intervention intermediate care teams and specialist community services for people with a long-term condition;

• Adult specialist and rehabilitation services – including 300 intermediate care beds, regional rehabilitation services and prison healthcare;

• Children & families – including universal and specialist community children's services for Birmingham;

• Learning disabilities – services for adults with learning disabilities in Birmingham;

• Dental – tertiary and secondary dental services at the Birmingham Dental Hospital and community dental services for Birmingham, Sandwell, Dudley and Walsall.

At this inspection we inspected the community health services for children and young people in Birmingham. We inspected as we had received information about low staffing numbers particularly in the health visiting service.

We previously inspected this core service in January 2020 when we rated the service as Requires improvement overall, requires improvement for Safe, Effective and Well led, Inadequate for Responsive and Good for Caring. We told the trust it must make the following improvements:

• The trust must ensure that all health visiting teams have safe staffing levels to provide children and their families with the care, treatment, support and advice they need. Regulation 18 HSCA (RA) Regulations 2014 Staffing

• The trust must ensure that all staff are supported at work to reduce the stress they are reporting. Regulation 18 HSCA (RA) Regulations 2014 Staffing

• The trust must ensure it reduces the waiting times for children and families to access neurodevelopmental services for an assessment. Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

Our findings

• The trust must continue to ensure it has effective governance systems and processes in place to identify, assess, monitor and mitigate risk within the children's community services it provides. Regulation 17 HSCA (RA) Regulations 2014 Good governance.

We found at this inspection that these requirements have been met.

What people who use the service say:

Parents said staff were approachable, friendly and they were happy with support given. Parents had used the 'Hub' when they had concerns about their baby and had found the advice given useful.

Parents said that health visitors listened to them and were helpful in giving them advice.

Parents said the health visiting service had improved since they had their other children and they felt well supported.

Parents said that staff were very supportive, were amazing and brilliant.

Overall summary of this inspection:

- The service had enough staff to care for children, young people and families to keep them safe.
- Staff had training in key skills, understood how to protect children, young people and their families from abuse, and managed safety well.
- The service managed and controlled infection and prevention risks well. [EN1]
- Staff assessed risks to children, young people and families, acted on them and kept good care records.
- Where staff gave medicines, these were managed well.
- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment to children, young people and families in a holistic way.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff worked well together for the benefit of children, young people and their families, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided social, emotional and practical support to children and young people, and families.
- The service planned care to meet the needs of local people and took account of people's individual needs.
- People could access the service in a flexible way.
- Leaders ran the service well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported and valued. They were focused on the needs of children, young people and families. Staff were clear about their roles and accountabilities.

Our findings

- The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff in some offices did not know where the defibrillator was kept.
- Staff did not always make it easy for people to give feedback.
- Staff did not always have time to keep children's and young peoples records up to date.

Is the service safe?

Good 

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. 86% of staff had received their mandatory training in March 2023.

The mandatory training was comprehensive and met the needs of children, young people and staff. Mandatory training included the following: infection control, equality and diversity, health and safety, safeguarding adults and children, fire, manual handling, conflict resolution, Prevent, resuscitation and bullying and harassment.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. Since April 2023 staff had received training on working with people with a learning disability and autistic people which now forms part of the trust's mandatory training programme.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they received an alert when their mandatory training needed updating and found this useful in reminding them.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse.

89% of staff had received training in safeguarding children level 2 and 97% of staff had received this at level 3 in March 2023. All staff eligible to receive this training at level 4 had received it in March 2023.

84% of staff had received training in safeguarding adults' level 2 and 90% of staff had received this training at level 3 in March 2023.

Our findings

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had good understanding of how to respond to families at risk of domestic abuse. They worked with other agencies to safeguard people from harm. Records included a 'flag' where there were safeguarding concerns so that staff were easily alerted to these. Staff received PREVENT training to help staff recognise the signs of radicalisation and help to prevent this.

Staff knew how to identify children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had safeguarding supervision every three months which supported them to identify where children were at risk of abuse.

Records showed that health visitors attended child protection case conferences and worked with social workers to decide how the child's care and support was to be managed.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke with knew how to make a safeguarding referral and liaised with the local authority safeguarding teams.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

The service generally performed well for cleanliness. Staff received training in infection control as part of their mandatory training. The areas we visited were visibly clean and tidy. We observed staff using hand gel to clean their hands and adhering to the bare below the elbow guidance, in line with national good hygiene practice. We also observed staff practice good hand hygiene within family homes. In each team there were infection control champions who modelled good practice in infection control and completed audits.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had easy access to PPE and took this with them on visits to homes. We observed staff wore gloves when weighing children and made sure the weighing scales were cleaned before use. Staff also used a paper roll to line the baby scales and replaced it after each use.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaned equipment after each use. We observed where equipment was stored and used in the offices that staff labelled it to show when it was last cleaned. Practitioners used toys and games to engage and interact with children. Staff cleaned toys using antibacterial sanitary wipes, adhering to guidance outlined in the toy cleaning practitioner guide.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. When providing care in children and young people's homes staff took precautions and actions to protect themselves and children, young people and their families.

Staff carried out daily safety checks of specialist equipment. Staff had ensured that equipment such as weighing scales were checked and calibrated regularly to ensure they were accurate.

Our findings

Staff at Richmond Primary Care Centre were not aware where the defibrillator was kept. They had received training in resuscitation but said they would call 999 if a person had a cardiac arrest in the clinic. Managers told us they would ensure that staff were aware of this. Staff who managed the office who did not work for this trust regularly checked the defibrillator to make sure it was working, and we saw records of this.

Staff disposed of clinical waste safely. We observed staff ensuring that clinical waste was disposed of safely and in the appropriate bags. In people's homes staff ensured they disposed of waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff had training in identifying children with deteriorating health needs and National Early Warning Score (NEWS) 2. Records showed that staff in the complex care team had used the tool appropriately to assess a child when they were becoming unwell.

Staff used a caseload capacity tool to determine workload which included acuity of the child. Some staff said they had three visits a day plus one from their caseload. This meant they did not always have time to complete their records. These were done in extra time which they claimed for. Staff said the average caseload for a full-time Strengthening Families health visitor was 40.

Health visitors did not do birth visits virtually but always visited the child at home so they could complete a robust assessment of the home environment and any risks.

Staff followed the trust 'did not attend' policy and ensured contact was made with the child and family to reduce risks and ensure they received the health advice for their child. Staff knew patients and their individual needs so the reasons why they may miss appointments and tried to be flexible to encourage them to attend.

Staff completed risk assessments where needed for children and reviewed this regularly. For staff that worked in the complex care team in patients own homes an assessment of the risks in the home was undertaken and reviewed regularly. This included making sure medical equipment and hoists were checked and serviced regularly.

Staff knew about and dealt with any specific risk issues. Staff working in the complex care team had training in pressure ulcers and how to support the patient to maintain healthy skin. Staff had training on meeting individual patients' medical needs which included care of the patient's tracheostomy. Staff had training in sepsis. They had cards which showed the symptoms of sepsis and how to identify early deterioration in the child or young person.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). Staff knew how to contact mental health services if needed. They had contact with the perinatal mental health team from the local mental health trust. They also liaised with GP's and discussed people who needed support with their mental health. Staff also asked questions about parents' mental health and assessed the risks of deterioration.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Records showed that staff documented when they handed over the care of a child or young person to another staff member within the trust or to other professionals involved in the person's care.

Our findings

Shift changes and handovers included all necessary key information to keep children and young people safe. Staff attended daily safety huddles which had been introduced recently since the COVID-19 pandemic and to meet the requirements made at our previous inspection.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep children and young people safe. Managers and staff told us that staffing was an issue. However, managers had responded to the national challenges of recruiting health visitors by developing a safer staffing tool and prioritisation matrix. Since January 2023 they had developed the 'hub' which at the time of inspection covered three areas of Sutton Coldfield, Erdington and Selly Oak. At the 'hub' there was a clinical services manager who had been in post for 2 weeks and 6 health visitors. The trust had advertised for a band 7 clinical lead, band 6 health visitor, 5 band 5 nurses and an allied professional. The trust said they would need these staff in post before rolling the 'hub' model out to other areas within the city. They did not use bank staff at the 'hub'. Some health visitors worked between sites and worked 3 days at the 'hub' and 2 days in local teams.

The service had reducing vacancy rates. The trust had used various initiatives to try and recruit staff, these included using a recruitment agency, attending job fairs and national nursing events to promote the service. They increased the number of health visitor students in the trust. Last year there were 2 cohorts of 15 students each, this year had increased to 2 cohorts of 20 students in each. The trust had introduced student contracts which meant students needed to work in the city for 2 years post qualifying and they hoped this would improve staff retention.

Managers accurately calculated and reviewed the number and grade of staff needed for each team, in accordance with national guidance. The trust launched a new skill mix model last year and strengthened specialist teams to support the families of greatest need. This included creating band 7 posts of Strengthening Families health visitors. Staff told us it was difficult to recruit to band 6 posts and some of the band 6 staff had been promoted to band 7.

Managers could adjust staffing levels daily according to the needs of children and young people. Staff told us managers worked with other team managers to look at whether they could allocate children to a neighbouring team if needed so they would be seen on time.

The service had reducing sickness rates. The sickness level across the core service in March 2023 was 6%, which had reduced from 8% in April 2022.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff had often worked as permanent staff in the service before, some had retired and returned, and some permanent staff worked extra hours on the bank. This meant they were familiar with the service and the area. Bank health visitors said they were allocated the new birth visits and then visited the same baby for the 6-to-8-week check so there was some continuity. Agency staff were not used to cover the health visitor's role.

The trust had a lone working policy which staff followed. Staff used What's app groups to communicate with each other on visits when needed. Managers monitored risks of where staff were visiting and where needed two staff were allocated to visit.

Our findings

Records

Staff mostly kept detailed records of children and young people's care and treatment. Records were clear, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. All staff, including bank staff, could access the trusts electronic records system. The trust had put in place a 'total mobile system' where staff could record a verbal entry on their phone which they attached on the electronic records system when back at the office. Staff said this was good for progress notes but not for full assessments. Staff said that the electronic records system could sometimes be slow. Assessment forms had been updated and included information about all the child's needs. However, we saw in two patients 'Red books' that information about family history was incomplete and there was incomplete information recorded at the child's 9–12-month review.

When children and young people transferred to a new team, there were no delays in staff accessing their records. All staff had access to the electronic records system and patients 'Red books' were in their homes with their parents.

Records were stored securely. The electronic records system was password protected. We observed staff locking their computers when moving away from their desks, so the records were not visible to anyone in the office. Staff ensured information was kept confidential when speaking to other staff about children or families in the office.

Medicines

The service used systems and processes to safely administer, record and store medicines. However, the only medicines the health visiting service administered were vitamin drops.

Staff followed systems and processes to administer medicines safely. Staff provided advice to children, young people and their carers about their medicines. We observed staff giving vitamin drops for the child to parents on visits and advising how and when to give. Staff recorded this advice on the child's records. They also advised parents how to store them safely in their home. Staff did not take more medicines than needed to reduce the amount of time they were stored in the staff members car.

Staff completed medicines records accurately and kept them up-to-date. Staff recorded in the child's 'Red book' the serial number and expiry date of the vitamin drops and recorded this on the child's electronic records. Staff checked on the visits that medicines stored had not exceeded the expiry date. They advised parents on how to get a further prescription from their GP.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff had raised as an incident that they did not always have time to do record keeping when needed. This was on the trust risk register and managers were working to recruit staff to relieve the pressure on existing staff.

Our findings

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could access the trust electronic incident reporting system.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Staff spoken with understood the duty of candour and their responsibilities.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to children and young people's care. Staff told us they received feedback through 'safety huddles' and 'Team talk'.

There was evidence that changes had been made as a result of feedback. Staff told us how a birth visit was missed which was reported as an incident. The visit was missed because the email went to the staff old email address. From this they have learnt that when setting up a new team not to send emails until sure it is fully set up.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. Records showed that incident investigations involved children, young people and their families where appropriate.

Managers debriefed and supported staff after any serious incident. Staff said that managers were supportive and there were debriefs and an opportunity to discuss any serious incidents as a team and with their manager. Staff said they could make suggestions on improvements, and these were listened to.

Managers acted in response to patient safety alerts within the deadline and monitored changes. Staff told us they were aware of patient safety alerts and what needed to be done to ensure changes were made.

Is the service effective?

Good ↑

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff ensured that health visitor visits were done as required to meet national guidance. Staff delivered the National Child Measurement Programme (NCMP). Staff visited school age children in Reception and Year 6 to record their height and weight during the first term of the new school year. This included sight and hearing tests to identify any sensory needs. Children had their height and weight measured as part of a mandated screening for trends in obesity. Last year the trust screened 97% of eligible children in reception year and 96% of eligible children in Year 6 and are on track to deliver this year. They had measured 80% of eligible children by the time of this inspection. They had also delivered 30-minute training sessions on healthy diets to lunchtime supervisors in schools across the city.

Our findings

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. Staff discussed these in safety huddles. We observed staff asked questions during visits about children's and their parents psychological and emotional needs.

The trust was not commissioned to provide sexual health services that traditionally would be part of the school nurse role. We observed and saw in records that staff signposted parents and young people to the local commissioned sexual health service 'Umbrella'.

Nutrition and hydration

Staff regularly checked if children and young people were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed staff speaking with parents about their child's diet and offering advice about healthy eating where appropriate.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. Staff from the complex care team who supported children in their homes and schools recorded this where needed. Records indicated what the required number of fluids and nutrition was for the child each day and how to escalate to nurses and medical staff if needed.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Staff measured children's height and weight and calculated their body mass index. Where this was low, they screened the child using the Malnutrition Universal Screening Tool (MUST). Records showed that where needed referrals were made to dietitians and staff continued to monitor the child's body mass index. They also gave advice to the child, their parents and the school where appropriate.

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it. Parents said that advice from the dietitian had been helpful. There was also a nutrition nurse in post who helped staff to support children who had a gastrostomy.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The service participated in relevant national clinical audits. For example, the Children in Care service had completed audits as per National Institute for Health and Care Excellence (NICE) guidance to ensure that letters had been sent for children leaving care. Audits were completed to ensure that children in care received their initial health assessment in accordance with national timescales.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. For example, staff completed audits to assess the compliance of special school meal provision with the International Dysphagia Diet Standardisation Initiative (IDDSI) framework. This helped to ensure that where needed children were provided with the correct texture of food to meet their needs.

Our findings

Managers and staff used the results to improve children and young people's outcomes. Records showed that children who were ventilated long term had their care plans reviewed, implemented effectively in line with West Midlands best standards.

Staff had completed audits to ensure compliance with NICE guidance for obesity in childhood.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. These included for the complex care team essential care audits every three months of how staff are supporting patients with ventilators or have tracheostomy. There were also audits of caseloads, care plans and records.

Managers used information from the audits to improve care and treatment. Improvement is checked and monitored. Team managers were responsible for setting action plans following audits. Information from audits were reported back to the relevant trust committees and staff responsible were allocated to check and monitor the improvements made.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Managers had developed the 'hub' model of working to ensure that calls from parents and carers were answered promptly and people got the care and support they needed. To develop the 'hub' managers had visited 'hub' models across the country and researched to see what would work well for a city like Birmingham.

Managers shared and made sure staff understood information from the audits. These were shared via emails, newsletters, in 'safety huddles' and through 'Team talk'.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Staff told us they had good access to training and had protected time to complete their mandatory training. However, some staff said they did not always have the time to complete competency assessments for work they were now expected to do, for example, 6-to-8-week checks. Managers said they monitored this through supervision and gave staff protected time to ensure that all staff had the time to do this.

Managers gave all new staff a full induction tailored to their role before they started work. This included a competency framework that they completed once they had started.

Managers supported staff to develop through yearly, constructive appraisals of their work. Across the children and families division 82% of staff had received an appraisal at time of inspection. Managers knew where appraisal rates were lower than expected and had a plan in place to address this.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff were expected to attend daily 'safety huddles' where they could do so and if not, available minutes were kept which all staff could access.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff working in the complex care team had access to training to support individual patients. Managers assessed competency of each staff member to work with and support individual patients. This included individual plans to deal with medical emergencies.

Our findings

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff were supported to attend health visitor forums which were held 3 to 5 monthly to share good practice. There were associate nurses at band 5 in post to improve the skill mix in teams.

Managers made sure staff received any specialist training for their role. Staff had opportunities to participate in a variety of training courses either e-learning or face to face. These included: supporting people with a learning disability and autistic people, domestic violence, female genital mutilation (FGM), bereavement support, palliative care, mental health, dysphagia, paediatric tracheostomy, nutrition and feeding, bowel and bladder care, communication including Deaf communication, physiotherapy and speech and language therapy.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Staff told us they had 'Team around the family' meetings with social workers, housing and police where needed to discuss families that needed a multi-agency approach to keep them safe. Staff said these meetings were helpful and supportive to families.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff contacted the local authority safeguarding teams where needed. Within the trust there were staff who worked primarily with families who had been homeless and were living in temporary accommodation. Staff also worked with domestic abuse agencies where appropriate to ensure that families who were living in refuges or temporary accommodation got the support and healthcare the children needed.

Staff referred parents, children and young people for mental health assessments when they showed signs of mental ill health, depression. Staff were aware of local mental health teams and how to contact them where needed. Staff discussed with children and their families their emotional needs during the visits we observed.

Staff asked probing questions to determine whether parents were experiencing mental ill health and signposted them to relevant services if needed. Staff told us they referred parents to their GP for more support with their mental health needs when required.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. On visits we observed staff giving information to parents on promoting healthy lifestyles. Staff asked parents whether they smoked or drank alcohol and offered advice where needed. Staff also gave advice on healthy eating and exercise for children. Staff ensured that children were registered with a local dentist and gave parents advice on this where needed.

Staff assessed each child and young person's health during visits. We observed that the assessment forms during the universal mandated visits (birth, 6-8 weeks, 9-12 months and 2 ½ years) included questions about the health of the baby or child and staff advised parents on promoting healthy lifestyles. The 2 ½ year checks are supported through partnership with Children's Centres with the health visitors seeing vulnerable children for this mandated contact face to face.

Our findings

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Records of young people over 16 years old who used the complex care service showed that staff had assessed the person's capacity to make a decision about their care and treatment.

Staff made sure children, young people and their families consented to treatment based on all the information available. Records showed that families were involved where a young person over 16 years did not have the capacity to consent and consented to treatment.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. Records of children and young people who used the complex care team included best interests' meetings about how decisions were made.

Staff clearly recorded consent in the children and young people's records. Records clearly showed how consent was obtained. Staff discussed with parents and children what care and treatment they were offering and asked for their consent.

Staff received and kept up to date with training in the Mental Capacity Act. In April 2023 86% of staff in this core service had received training in the Mental Capacity Act.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We saw staff had completed audits of children's advance care plans where appropriate. Audits showed that advance care plans included the wishes of the child and family and were in accordance with the Mental Capacity Act.

Is the service caring?

Good 

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We observed on visits to people's homes that staff were kind, respectful of people's homes and spoke to people with compassion.

Children, young people and their families said staff treated them well and with kindness. Families said staff were friendly and approachable.

Our findings

Staff followed policy to keep care and treatment confidential. We observed that staff kept information confidential where needed on home visits. They discussed what was needed with the parent but were aware of not sharing information with other family members present.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. We observed staff speaking to parents who had mental health needs with empathy and understanding.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. We observed staff spending time with parents discussing their cultural and religious needs to help understand how best to meet these.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. We observed staff offering emotional support to families in a kind and compassionate way. We observed staff speaking to both parents (where appropriate) individually about their emotional needs. Staff were aware of the emotional impact on children, young people and their families living in temporary accommodation and supported them with this.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff received training on communication skills and building rapport and trust with families.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's, wellbeing. Staff were supportive of the family and understood their needs. We observed and saw records of how staff supported the families of children who were cared for by the complex care team.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. The complex care team produced a leaflet which clearly stated what the service provided and to whom.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. We observed staff from the complex care team using communication aids appropriate to the child or young person to help them communicate.

Children, young people and their families could give feedback on the service however not all staff were aware of this. We observed some staff asking parents to complete a survey at the end of their visit, but other staff did not know about these.

Staff supported children, young people and their families to make informed decisions about their care. Records showed and we observed that staff gave children, young people and their families the information they needed in accessible formats about their care and treatment.

Our findings

Patients gave positive feedback about the service. Patients and their families told us that staff were supportive, kind and compassionate.

Is the service responsive?

Good 

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. Commissioners told us the trust worked with them to adapt to the changing needs of the local population. The trust had developed the 'Temporary accommodation' team in response to supporting families who were homeless. There had been many families move into the city who were seeking asylum and staff worked with agencies to support these families. Commissioners told us that the city had accepted 100 children who had cancer from Ukraine at the start of the war. They said the trust had managed this challenge well and worked in a collaborative way to deliver this care and support.

Staff told us they had identified that there were children in the city who were sharing a bed with other family members. Health visitors were asked to report on this and liaised with a charity to provide beds to these children. We observed on visits that health visitors asked questions about sleeping arrangements and looked around the home to see if children were without a bed. If there was a need staff liaised with the local charity to provide these.

Facilities and premises were appropriate for the services being delivered. Where we saw baby clinics held the premises were appropriate.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. Staff knew how to contact the mental health teams when needed.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. The trust had a complex care team and a children in care team. The children in care team had been developed further due to demand to include children seeking asylum who were unaccompanied.

Managers monitored and took action to minimise missed appointments. Administrative staff sent a text message to parents and carers the day before appointments to reduce the likelihood of not attending appointments. Managers monitored the number of missed appointments and looked at ways to reduce these.

Managers ensured that children, young people and their families who did not attend appointments were contacted. When a child missed two appointments administrative staff referred this back to the health visitor who did a home visit.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Our findings

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. The complex care team worked with children who had a learning disability with additional medical needs. Staff supported the child in their own home and to school. We observed that staff had good working relationships with school staff where they supported children.

The trust had developed new roles of Strengthening Families workers at band 7. They supported children, young people and families who had more complex needs and risks and this helped to support the newly qualified nurses with training and advice.

The trust had set up temporary accommodation teams to work with families who were homeless and living in temporary accommodation: there were 2 in Yardley, 2 in Ladywood and 1 in Edgbaston which covered the areas where most of these families were in temporary accommodation

Staff supported children and young people living with complex health care needs by using 'This is me' documents and passports. Records completed by staff in the Complex Care team included a 'This is me' document which included pictures and easy read format to show the young person's likes, dislikes and how they wanted to be supported. Children and their families were involved in these.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff understood the policy and who to contact within the trust to help them develop information that was accessible.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff had easy access to interpreters either on the phone or face to face where possible. We observed interpreters present on home visits.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers told us there was not a waiting list for the health visiting service but children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. The 'hub' was developed in January 2023 in three areas: Sutton Coldfield, Erdington and Selly Oak. Referrals for these areas come from midwives, Birmingham Children's Trust (local authority), safeguarding, police and adult services who worked with the child's parents. The 'hub' is staffed by administrative staff, health visitors and a clinical services manager. They worked together to answer calls from parents, carers and professionals. In areas where the hub is not yet set up referrals go to the local teams across the Birmingham Forward Steps services.

However, there were waiting lists for children waiting for Autistic Spectrum Disorder (ASD) and attention deficit hyperactivity disorder (ADHD) assessments. The trust told us that in April 2022 there were 2097 pre-school children on the ASD pathway and the average waiting time for assessment was 53 weeks. In March 2023 there were 810 children on the pathway and the average waiting time was 32 weeks. For children of school age in April 2022 there were 401 children on the ASD pathway with an average waiting time of 31 weeks. This had decreased to 160 children on the pathway in March 2023 with an average waiting time of 20 weeks.

Our findings

The number of children on the pathway awaiting assessment for ADHD had increased from 874 in April 2022 to 1560 in March 2023. The average waiting time for these assessments was 21 weeks in April 2022 and due to the increase in the number of children had risen to 27 weeks in March 2023. However, the trust had increased their staffing to meet this demand and were continuing to look at ways to reduce the waiting time.

Staff supported children, young people and their families when they were referred or transferred between services. There were weekly allocations meetings for health visitors, and we observed two of these. Administrative staff received a spreadsheet of new births to be allocated. Managers at the allocation meeting also discussed children who were under safeguarding teams and allocated them to a health visitor also. Managers used a capacity tool to allocate. This looked at the number of 'universal plus' children on the health visitor's caseload. 'Universal plus' is for children who need to be allocated a health visitor due to their medical or social needs.

The trust stopped drop-in well baby clinics during the COVID-19 pandemic owing to national guidance regarding infection prevention and control. During the services recovery from COVID-19 the 'hub', appointments were booked by the hub and in other areas parents booked a clinic appointment. Staff said these pre-booked appointments worked better as people had 30-minute appointments and did not have to wait in the clinic. Staff booked home visits when clinics were full, however they also discussed risks at home and whether a home visit was needed rather than a clinic so the health visitor could see the home environment. For children who had recently arrived in the country or were new to the area, home visits were always scheduled.

Managers worked to keep the number of cancelled appointments to a minimum. When children and young people had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. People told us they knew how to make a complaint and we observed staff giving information to families during visits. In the offices we visited we saw the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew what to do if a parent or carer made a complaint and tried to resolve it first. If this could not be done, they knew how to escalate the concerns and informed complainants of the process.

Managers investigated complaints and identified themes. The trust told us that in the last 12 months they had received 37 complaints about this core service. Two of these had been upheld, 4 were not upheld, 22 were partially upheld, 1 had been redirected to another service and 8 investigations were ongoing. The trust told us the themes of these were: lack of care and support, staff manner and attitude, lack of communication and waiting times for appointment. These were shared with staff and action plans put in place to address these.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service during 'safety huddles', 'Team talk' and via emails and newsletters.

Our findings

Staff could give examples of how they used patient feedback to improve daily practice. Staff told us they updated information and ensured it was provided in a variety of languages after feedback from parents. Parents whose children used the services of the complex care team suggested that healthcare assistants should be able to use Makaton sign language. In response to this the trust had provided training to staff during their team away day. Where children used more than the basic Makaton signs the staff members working with the child received further training.

Is the service well-led?

Good 

Leadership

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

Staff said that managers were approachable and were available to speak with when they needed support.

Staff at band 7 and above had access to leadership courses. Senior leaders encouraged staff to participate in this training.

Managers were aware of the staffing issues. In response to this they had developed the 'Hub' to support the local teams. Staff at the 'Hubs' could book appointments and answer parents and carers questions and decide whether further advice was needed from health visitors or school nurses.

The trust held exit interviews when staff left the service and themes of these were reported back to senior managers.

Vision and Strategy

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

Staff were aware of the vision of the organisation. This was communicated to staff through 'safety huddles' and 'Team talk'. The vision of the trust was 'Best care: healthy communities.' The trust values are: Caring, Open, Respectful, Responsible and Inclusive.

The trust worked with commissioners, their partner organisations such as Birmingham Children's trust, Barnardo's and Spurgeons to ensure that their strategy met the local populations needs.

Culture

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

Our findings

Staff told us that there was good teamwork in the trust. Staff told us they had a 'buddy' system which meant they had support from their peers.

Staff were aware of the Freedom to Speak Up process and how to contact them, although some staff said they were concerned that they would not be treated as anonymous when raising concerns. Managers told us they would monitor this as they wanted all staff to be able to speak up anonymously if they wanted to. In teams there were Freedom to Speak Up champions to enable staff to speak to peers if they had concerns.

Staff said that the trust promoted their wellbeing at work. The trust had provided vouchers for staff at Christmas. Staff also said that a few years ago the trust had given all staff lunch bags at a wellbeing event and some staff said they still used these to bring their lunch to work. Staff said that wellbeing sessions were held online and now face to face monthly for staff to attend. Staff had access to stress risk assessments when needed and had access to support from Mind.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had an audit programme, and these were fed back through the relevant committees aligned to the trust board. Committees scrutinised the audits to ensure that the trust delivered its purpose and children, young people and their families received the service and these were discussed by senior managers. Improvements were made because of audits and local managers were aware of action plans to address the improvements needed within their teams.

There were weekly meetings that staff were expected to attend which were about their clinical work and the operational meetings. There was a set agenda for these meetings and minutes were kept and shared with staff.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

As part of their commissioned contract for school nurses the trust is expected to attend all initial child protection conferences and complete a health assessment for all children on child protection plans. The trust told us that this year they have seen a 30% rise in referrals to safeguarding school nurses. They have highlighted as a risk of school nurse capacity to attend case conferences and complete plans in line with this rise. This meant that children were waiting up to 10 weeks to see a school nurse. To mitigate this risk, they agreed with Birmingham Children's Trust (local authority) and the integrated care board that they will now only attend child protection conferences if the child has health needs or if the trust is completing intervention with the family. This was monitored by safeguarding leads within the trust to reduce the risks of this approach.

The trust had business continuity plans in place to ensure that in the event of unexpected events such as fire or cyber-attack they were still able to deliver a safe service.

Information Management

Our findings

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to laptops and mobile phones before they started to work for the trust. Staff said this was an improvement and meant that staff were able to work more efficiently and feel part of the team. However, some staff said that when working remotely the connection could be slow and it was difficult to complete assessments on their mobile phones.

Engagement

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

Commissioners told us there was now more collaborative working. The trust worked in a less traditional way, involved staff and understood the need to do things differently. They said there was partnership working across the city where the trust was the lead partner for children 0-19 years. The trust worked with organisations such as Barnardo's and Spurgeon's and with city council staff in the Children's Centres. Commissioners said that they had been successful in commissioning 'Family Hub' where the trust had led jointly with other organisations.

Commissioners completed a financial review of the school nursing service in 2018 and when they released the tender for this there were no bids. The trust was given the contract in 2019 to deliver a service with a 52% decrease in funding from previously. They worked with commissioners, the public and local organisations to deliver a different service. This included: Health related school absences where schools referred children to the service, training in medical needs to school staff, developing care plans for children with medical needs, to deliver the National Child Measurement Programme in schools and Safeguarding.

Managers told us they were working with the city council on a protocol for frequent health related school absences whereby GPs were linked into the process, so schools could refer into GPs in addition to school nurses which they hoped would release some capacity for the service.

The medical needs training is offered to mainstream schools to support children with the following medical needs: asthma, anaphylaxis, diabetes, epilepsy and administration of Buccal medicine for epilepsy. The nurses had delivered 686 sessions to 336 schools in Birmingham from September 22 to May 2023.

The medical needs care planning is when schools refer a child into the service, the service writes a care plan for a child with medical needs. In the year 2021/22 the trust completed 1,683 care plans and knew this year this has increased already in terms of demand. Review of care plans is only done if the child's medical needs had changed to reduce the risk of not completing these plans.

The trust is aware they must work differently to become part of the integrated care system in the city. They were working collaboratively with the Integrated Care Board and local community groups who represented the local people to develop what they offer for children and young people across the city rather than the traditional school nurse role.

Staff told us there was an annual staff survey that they could complete. There were also smaller more targeted 'pulse surveys' so managers could assess how staff were feeling about working for the trust. They met with staff to discuss the findings and developed action plans where needed to make improvements.

Our findings

Staff told us that there were equality groups within the trust, and they were given protected time to attend the meetings. Equality groups leaders attended trust board meetings to develop the work of the trust and reduce inequalities for trust staff and the communities in which they worked.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff told us about a new initiative that was developed in February 2023 called “School readiness”. This was a video that was shared with school staff and parents to support children to be ready for school and includes information about toilet training and sleep.

At Hall Green we saw a pilot project where family network meetings were held. This was a multi-agency approach to discuss families where several agencies (for example, children's services in the trust, police, social services, housing services) were working with them and how best to support the family. They discussed what was working well, what are any issues, who is the best agency to support them, and any actions needed to support the family further. This was currently a pilot but was hoped to be rolled out across the city.

Our findings

Areas for improvement

SHOULDS

- The trust should ensure that all staff are aware of the patient satisfaction survey and how they can signpost parents and carers to complete feedback.
- The trust should ensure that all staff are aware of the location of defibrillators in clinics where these are provided.
- The trust should continue to recruit staff so that staff do not have to work extra hours to ensure patient records are completed in a timely manner.

Our inspection team

Our inspection team was made up of three inspectors and three specialist advisors with experience of community nursing and one who had a school nursing background. During the inspection, the team:

- Visited 7 locations where staff were based across the city including the newly formed 'Hub'. This included meeting with staff from the complex care team, children in care team, school nurses and health visitors.
- Accompanied staff on 15 visits to people's homes, schools, hostels for the homeless, observed well baby clinic.
- Met with eight children who use the service and 15 of their carers.
- Spoke with 52 members of staff including health visitors, health care assistants, school nurses, team leaders and managers.
- Spoke with representatives from 3 other organisations the service works closely with.
- Reviewed 21 care records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.