Birmingham Community Healthcare NHS Trust

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Community health services for children, young people and families

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Community health services for children, young people and families. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Community health services for children, young people and families and these are brought together to inform our overall judgement of Community health services for children, young people and families

Summary of findings

Ratings

Overall rating for Community health services for children, young people and families	Good
Are Community health services for children, young people and families safe?	Good
Are Community health services for children, young people and families effective?	Good
Are Community health services for children, young people and families caring?	Good
Are Community health services for children, young people and families responsive?	Requires Improvement
Are Community health services for children, young people and families well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Services for children, young people and families were judged to be good. At the time of the inspection services were judged to be safe. Risk was managed and management plans were in place for most services to address concerns regarding expanding caseloads and complexity. There was a robust system in place for clinical safeguarding supervision and all staff reported receiving regular supervision.

Care was effective. The majority of care was evidence based and followed recognised and approved national assessment tools and guidance. There was good multidisciplinary team working within the trust and joint working across local services. There were examples of excellent multi-disciplinary working at Allen's Croft Children's Centre hosting awareness events in partnership with local and national organisations.

Care and treatment of children and support for their families, was flexible, empathetic, and compassionate.

The trust promoted self-care to empower children and families. Services were committed to delivering care as close to home as possible. There were individual examples where services had learnt from complaints and feedback.

Staff were passionate and proud about the care they provided, there was clear peer support and they felt supported by their managers. Concerns were identified with the responsiveness of services, and some, for example occupational therapy and speech and language therapy were failing to meet the waiting time targets. There was also a need to bridge the gap for the transition from children's to adult's services.

Several children and families services had won awards for practice and innovation, most notably the multi-agency team at Allen's Croft Children's Centre received a Nursing Times award for partnership working.

Summary of findings

Background to the service

Birmingham Community Healthcare NHS Trust children and families division delivered community based services to pregnant women, children and young people. It provided support for new parents; and children, up to school leaving age across universal and specialist services; and up to 19 years of age for young people with special educational needs. It provided a range of health services including health visiting, school nursing, community paediatric nursing, therapy and breastfeeding support; plus services for looked after children and safeguarding children.

The service had well embedded partnership working with families and other organisations across health, education, social care and local trusts. Care was delivered in a range of locations, including families' own homes, education settings from nurseries and children's centres to secondary schools, including special schools, as well as within community-based clinics.

The service provided community care primarily across Birmingham, but also Sandwell, Dudley and Walsall. It included a large urban conurbation with high levels of deprivation as well as pockets of relative affluence. The city's population was 1.1 million of who 85,000 were children aged 0-5 and 255,000 aged 6-19.

Our inspection team

Our inspection team was led by:

Chair: Dr Cheryl Crocker, Director of Quality and Patient Safety, Nottingham North and East Clinical Commissioning Group

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Dentist, Nurses, Therapists, Senior Managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Birmingham Community Healthcare NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.

Summary of findings

3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Birmingham Community Healthcare NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 23 and 27 June 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 46 locations which included 13 community inpatient facilities and the dental hospital. The remaining locations included various community facilities. We carried out an unannounced visit on 27 June to one of the inpatient units.

What people who use the provider say

In addition to the children, young people and families that we spoke with as part of the inspection, we received 23 completed comments cards from parents whose children had used services provided by the children and families teams. The vast majority of responses were very complimentary about the staff and the care and attention their children had received.

The parents we spoke with all told us how kind and caring the staff were and how well they understood the needs of the children. Satisfaction surveys that the trust conducted were positive in their outcomes and improvements in the Family and Friends test were noted.

Good practice

Our inspection team highlighted the following areas of good practice:

- There was a robust system in place for clinical safeguarding supervision and all staff reported receiving regular supervision.
- There were examples of excellent multi-disciplinary working at Allen's Croft Children's Centre hosting awareness events in partnership with local and national organisations.
- Care and treatment of children and support for their families, was flexible, empathetic, and compassionate. The trust promoted self-care to empower children and families. Services were committed to delivering care as close to home as possible

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Appropriate infection prevention audits and learning should be put in place to demonstrate improvement in practice.
- Medication fridges should be tested appropriately to ensure their working efficacy is maintained.
- The trust should complete recruitment processes to fill vacancies across the organisation including administrative support staff.
- The trust should ensure that appropriate child protection supervision is provided for all relevant staff.
- The trust should engage staff more effectively in understanding the available performance information, and where necessary develop appropriate outcomes measures and audit programmes.
- Further action should be taken to ensure that access times are reduced where they in excess of referral to treatment time targets.

Summary of findings

- The trust should work with partners to ensure that transition between childhood and adults services is effective and reduces unnecessary patient and carer anxiety.

Birmingham Community Healthcare NHS TrustBirmingham Community Healthcare NHS Trust

Community health services for children, young people and familiesCommunity health services for children, young people and families

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good

Are Community health services for children, young people and families safe?

By safe, we mean that people are protected from abuse

Summary

Services were safe at the time of our inspection. The NHS Safety Thermometer measured children and families services Harmfree Care as 99.29% for 2013-2014. There were two reported serious incidents requiring investigation since January 2014. Both incidents had examples of clear learning and actions implemented as a result.

Staff followed the trust infection control policy. However, the staff survey 2013 showed that staff felt that hand washing facilities were not always available for use. This was a reduction from the 2012 survey and below the threshold for the lowest scoring 20% of all similar organisations.

Management plans were in place for most services to address concerns regarding expanding caseloads and

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Are Community health services for children, young people and families safe?

complexity. Health visitors told us that although their caseloads had reduced they were above the Community Practitioners and Health Visitors Association recommendations, making it more difficult to assess need and provide effective interventions. The National Health Visitor Implementation Plan to recruit 120 extra health visitors to Birmingham was underway and expected to reach target by April 2015.

There was a robust system in place for clinical safeguarding supervision and all staff reported receiving regular supervision. Staff at Quinton Lane worked with the local police to assess and reduce the risk to children in houses where there was a prevalence of domestic violence.

Detailed findings

Incidents, reporting and learning

Staff were aware of the systems to report incidents, accidents and near misses. Staff reported that they received feedback following incidents and that learning was shared across the services.

The NHS Safety Thermometer measured children and families services Harmfree Care as 99.29% for 2013-2014. Service level data regarding Harmfree Care was displayed within some clinical services. There were two reported serious incidents requiring investigation since January 2014. Both incidents had examples of clear learning and actions implemented as a result.

For example, one of the incidents highlighted on the Strategic Executive Information System (STEIS) record as a serious incident where a child had been seriously injured by breaking a leg, was subject to a full root cause analysis investigation. An action plan was devised to manage risk and prevent similar incidents reoccurring. We saw aspects of this action plan in place, where children's manual handling care plans had clear transfer instructions documented for all health care professionals to access, in order to minimise risk and safeguard children.

The 2013 staff survey demonstrated that 85% of staff agreed that the organisation encouraged the reporting of errors, near misses or incidents. The results showed that 88% of staff knew how to report concerns about fraud, malpractice or wrongdoing. However both of these figures had deteriorated slightly from the 2012 survey.

Between July 2013 and June 2014 there had been 453 incidents reported within children and families services. The health visiting service accounted for 254 of these incidents, with the highest contributors being patient incidents and staff, visitor and contractor incidents.

Cleanliness, infection control and hygiene

Staff were aware of and followed the trust infection control policy. We observed that staff were bare below the elbow; used alcohol hand gel and used personal protect equipment. There was alcohol hand gel in service areas, waiting rooms and in the cars of health visitors that completed home visits.

However, the 2013 staff survey indicated that 46% of staff felt hand washing facilities were always available for staff to use; and that only 40% felt hand washing facilities were always available for service users to use.

Staff told us that there was no hand washing audits and that some services had no infection control audit. The children and families operational manager's meeting minutes from May 2014 indicated that there was a plan in place to audit hand washing once a year and infection control in clinical areas monthly, but did not state when this was going to be implemented. Staff told us that the toys in the waiting area in the looked after children's service were cleaned weekly; however, the cleaning rota did not reflect weekly cleaning.

We identified a variety of different coloured bins across the service in clinic rooms and waiting rooms. The bins in some services were not labelled and it was not clear what their purpose was.

Maintenance of environment and equipment

The locations we visited were fit for purpose and maintained. Buildings had appropriate security measures in place. Plug socket covers were in place to reduce the risk of children sticking their fingers or an object into a wall socket. There was sufficient clean and functional equipment at services to ensure safe care.

Some sites had resuscitation equipment that was checked weekly to ensure equipment was fit for purpose. Resuscitation equipment at Respite Care Unit at Edgewood Road was locked in a cupboard, making it more difficult to access. Staff told us that they had requested a 'grab bag' but were yet to receive one.

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Are Community health services for children, young people and families safe?

At the looked after children's service there was clinical equipment, such as spill packs and urine collection kits, that had expired the use by dates, July 2008 and January 2014 respectively. We reported this to nursing staff who told us that they were aware that the equipment had expired but had not removed it from the service. We asked the nursing staff to dispose of the equipment.

Medicines

There was a trust controlled drugs procedure for children. Medication administration records that we reviewed were appropriately completed.

Although the majority of medicines were stored in the homes of children, and young people, those that were the responsibility of trust staff were safely stored. Fridge temperatures were monitored and discrepancies were dealt with appropriately to ensure that medicines remained effective. The fridges were meant to be monitored daily however records at the looked after children's service did not reflect this. Three fridges storing medication at the Springfield's Centre had expired their portable appliance testing (PAT) dates.

There had been 20 medication, medical gas and/ or medication delivery system incidents between July 2013 and June 2014. Five of these incidents had taken place at the Respite Care Unit at Edgewood Road. Lessons had been learnt and as a result medication was administered with two staff present, capability measures were in place and a medication audit had been implemented. However, staff told us that there was no specific paediatric medication prescribing training provided by the trust for staff to attend.

In May 2014 specialist school nurses had completed an audit to establish the focus of the Medical Needs in School Service (MNISS). It concluded that they will continue to support schools with training but significant service investment was required to meet the growing demand of the service.

Safeguarding

Staff were aware of local issues regarding safeguarding, such as the Office for Standards in Education, Children's Services and Skills (OFSTED) inspection that had rated the local safeguarding children's board as inadequate in May 2014. However, OFSTED had noted that 'Looked after children and young people experience good support for their health needs. Health reviews are timely and comprehensive and health needs are well considered in statutory reviews, with appropriate action plans developed.

The safeguarding children's team had an effective audit system and produced annual reports that summarised referrals, looked after children data and training compliance for children and family services'.

There was a system in place for clinical safeguarding supervision and all staff reported receiving regular supervision. There was child protection supervision delivered by the safeguarding team every quarter to health visitors. There was a safeguarding children annual report 2013-2014 prepared by the safeguarding children's team, which presented data in a monthly format. The latest months report showed that in March 2014, many staff had received appropriate supervision, 79% of staff in the safeguarding team and 83% of staff in health visitor groups were compliant with safeguarding supervision, failing to meet the 90% trust target. However, in the same month, 93% of staff in children and families services had received child protection level 1 training and 88% had completed higher level 2 and 3 child protection training, meeting trust targets.

In 2013 the safeguarding children's team had audited the volume and quality of referrals made by the trust to Birmingham's' children's social care services. As a result awareness was raised about safeguarding referrals and sharing appropriate information with other health professionals. Staff told us that all safeguarding concerns were reported to their manager and they shared information with other agencies where appropriate. If they needed advice they were able to contact the safeguarding team and the Birmingham Safeguarding Children's Board. Multidisciplinary safeguarding meetings were held with health visitors, general practitioners (GPs) and allied health professionals (AHPs). Staff were able to discuss and learn from safeguarding concerns, including serious case reviews at team meetings and training events.

In October 2013 the West Midlands Quality Review Service reviewed the paediatric speech and language (SLT) service. Reviewers were concerned about the implications of the 'gap' in commissioning of SLT services for child safeguarding, in particular the situation where children

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Are Community health services for children, young people and families safe?

with communication problems did not meet the 'threshold'. Safeguarding issues may not be identified because their communication issues are not being addressed.

Records

Most clinical records were paper based and were suitably stored. We saw electronic systems were passwords protected. There was a new electronic patient records system called RIO due to be launched later this year. Staff told us that they were involved with developing and transferring clinical assessment tools onto the system and training to use the system was due to be rolled out to staff in the autumn.

There were comprehensive, chronological records within most services. There were excellent records at the Barbara Hart House, with clear detailed care plans and documentation of care and treatment. However, we looked at three British Association for Adoption and Fostering forms which all contained illegible hand writing by medical staff, and three out of 10 growth charts were incomplete.

Audits of the quality of record keeping were performed across the service and any concerns identified were actioned for improvement; with the exception of Springfield's Centre where staff told us that they had never completed a documentation audit. The looked after children team annually audited 100 children's records from four bases; Bacchus Road Child Development Centre, Allen's Croft Children's Centre, Heartlands Child Development Centre and Sutton Cottage hospital. The April 2014 results showed improvements on presence of health plans, and asking if children had received a dentist and optician assessment in the past 12 months; however compliance with recording the child's name and date of birth was on each page of the assessment, had reduced. We were told by staff that the audit results and associated recommendations were circulated and discussed at meetings.

Health visitors told us that children and families personal details were often incorrect on the patient administration system (PAS). The SLT satisfaction survey (November-December 2013), indicated 18 out of 101 families had incorrect telephone numbers recorded by the service. The physiotherapy parent and carer satisfaction survey (December 2013-January 2014) had 23 out of 199 incorrect telephone numbers. We saw no evidence on survey action plans that addressed the incorrect telephone number of service users.

One young person at the looked after children's service had the incorrect address and out of date immunisation details on their records. Staff contacted the GP to gain the correct information whilst we were at the unit.

Lone and remote working

A lone working policy was in place and staff told us of the trust's protocols for arranging and carrying out home visits including maintaining staff safety. In addition to the trust policy, some services had 'buddy' systems in place to encourage staff to update one another of their location, to ensure someone always knew where staff were.

Staff told us sharing information about risk assessments for lone working with partner organisations was effective. Health visitors told us that they would do joint visits with other health professionals both from within BCHC and from other organisations, if the risk assessments indicated this was required.

The trust had provided mandatory conflict resolution training to staff every three years, lone working training was provided for new staff. Some lone working staff had lone working devices, however, some admitted to not using these devices and we saw no evidence of these being used during visits.

Adaptation of safety systems for care in different settings

Individual teams demonstrated ways they assessed and responded to risk in order to provide a safe service for children, young people and their families. For example, occupational therapy (OT) used a triage system to assess and prioritise patients' needs.

Assessing and responding to patient risk

Staff across the service told us that they prioritised their caseload to prevent risk escalating, and were able to prioritise high risk children first. However, this was getting more difficult given the increasing complexity of clinical needs for some children and young people.

Good

Are Community health services for children, young people and families safe?

Staff at Quinton Lane worked with the local police to assess the risk to children in houses where there was a prevalence of domestic violence. This meant that children at risk of harm could be identified earlier and health visitors could put actions into pace to reduce risk.

Staff at the Respite Care Unit at Edgewood Road were clear that if they did not have adequate numbers of staff with appropriate training they would not provide a service as it would compromise children's safety.

Staffing levels and caseload

Most teams told us that their caseloads were constantly expanding, funding was limited and staff often worked extra hours. The 2013 staff survey indicated that 53% of staff felt that there was not enough staff in the organisation for them to do their jobs properly. There were management plans in place for most services to address concerns, for example, since January 2014 vacancies had been managed in specialist nursing and paediatric eye service with four locums; and in community paediatrics with one consultant.

Health visitors told us that the service was, "safer" than previous years but avoided commenting directly on whether the service was currently safe. One health visitor commented that, "Some cases slip through the net", and described how some children were not referred or did not receive enough health visitor contact due to staff shortages.

The trust health visitor service had a total caseload of 81,467 families. Trust data indicated that health visitor caseload numbers were higher than the Community Practitioners and Health Visitors Association (CPHVA) recommendations, with approximately 407 families per whole time equivalent (WTE); approximately 29 of these were active cases. Health visitors told us that their caseload had reduced from 800 -1000 families. The CPHVA strongly discourage health care organisations from expecting health visitors to be responsible for more than 350 families as they believe beyond this number it is difficult to assess need and provide effective interventions. In areas of high need such as Birmingham, caseloads should be under 300 families. The National Health Visitor Implementation Plan (HVIP) to recruit 120 extra health visitors to Birmingham was underway with the WTE due to increase from 156 to 270.5. The target of 270.5 WTE was expected to be reached by the close of the HVIP in April 2015. Since 2013 health visitors had employed three locums to help bridge some of the gap, as all positions within a key team were vacant.

Each team told us that they did not have enough administration support and that on a daily basis qualified staff were completing administrative tasks. In OT we were told that there had been two incidents in the past two weeks where personal information had been sent to incorrect addresses as a result of qualified staff being under pressure and completing administrative tasks inappropriately. This was having an impact on patients being able to access services as phones were often constantly engaged. There had been two locums OTs employed since January 2014 to help manage the peak in workload.

Managing anticipated risks

Services now had plans in place to manage the risk of changes in demand and long waiting lists. For example OT services had accessed locum staff that were competent with paediatric OT care and treatment, to manage the increased demand on the service. Health visitors had access to bank staff that were familiar with the service in the event of busy periods or staff sickness. Other policies were also in place to deal with unexpected events, for example, the trust had a policy in place to cope in the event of a heat wave.

Major incident awareness and training

The immunisation children's team had an emergency plan in place should mass vaccines be required.

Good

Are Community health services for children, young people and families effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

The majority of care was evidence based and followed recognised and approved national assessment tools and guidance.

There were key performance indicators and individual patient outcomes for care and treatment in some services, and whilst some services had patient outcome data not all teams did. Performance information was available, but staff were not familiar with some of the trusts key performance reports.

New staff received a comprehensive induction. Annual appraisal, regular one to ones and clinical supervision were in place.

There was good multidisciplinary team working within the trust and joint working across local services. There were examples of excellent multi-disciplinary working at Allen's Croft Children's Centre hosting awareness events in partnership with local and national organisations.

Transition arrangements were strained across some services. The local child and adolescent mental health service was provided by a different provider and staff reported this service now had stricter referral criteria and had declined a number of the trust's referrals. Some delays were reported in referrals to social services due to the capacity and demand on the local authority. Staff felt this delayed appropriate care.

Detailed findings

Evidence based care and treatment

Most care was evidence based and followed recognised and approved national assessment tools and guidance. There was evidence of national and local guidance being discussed and reviewed at team meetings. Clinical care pathways were developed across the service for a variety of conditions using the National Institute for Health and Care Excellence (NICE) guidance, and the trust delivered the Healthy Child Programme, a Department of Health initiative. The programme included a series of reviews, screening tests, vaccinations and information to support parents and help them give their child the best chance of staying healthy and well.

Health visitors gave out Bookstart packs to children at home visits in line with the national early intervention and cultural access programme for every child. Physiotherapy and SLT services had developed their own assessment tool based on risk, impact, benefit of treatment and level of child ability.

The children's SLT service had developed and implemented evidence-based clinical tools and both the 'Ph@B' assessment tool and defined 'Packages of Care' were in use. The service was working with an external, professional expert to validate both the assessment tool and packages of care. The approaches had been used to standardise the care offered across Birmingham.

Pain relief

There was guidance in care plans about pain management for children where it was appropriate. We saw staff follow the pain management care plan and administer liquid analgesia to a child for pain control.

Staff told us that there was no specific paediatric medication prescribing training provided by the trust for staff to attend.

Nutrition and hydration

The infant feeding team and health visitors promoted and audited the number of breastfed babies in the area. Breast feeding initiation was low at 68.1% compared to 74.6% nationally. Breastfeeding prevalence at 6-8 weeks averaged 52.6% between September 2013 and March 2014, higher than the national average of 49%. Initiatives such as weekly breastfeeding workshops and peer support groups had been developed to promote breastfeeding. Quinton Lane health visiting team had designed a pictorial mood booklet due to be released which could be used to overcome language barriers. There were 'breastfeeding welcomed' signs across services. We witnessed at the Soho Health Centre a mother ask staff for somewhere private to breastfeed her baby, staff kindly directed the mother into a room close by for this purpose. However, one service user at Quinton Lane commented, "There was nowhere to breastfeed privately although it is a breastfeeding friendly building".

Good

Are Community health services for children, young people and families effective?

The trust had been assessed for the United Nations Children's Fund (UNICEF) stage 1 accreditation for the Baby Friendly Initiative, they were awaiting the result. Where appropriate children had nutrition and hydration care plans in place. One parent we spoke with at Allen's Croft Children's Centre told us that their child required additional hydration and that this was always provided. At Edgewood Road there was a choice of meals for children to choose from. For children who had communication difficulties there was a pictorial food chart for children to point and select their meal choice.

Patient outcomes

There were target driven key performance indicators and individual patient outcomes for care and treatment in some services. For example physiotherapy had a profiling tool that assessed children's physical presentation, risk and benefits of intervention, this was completed at each assessment to monitor intervention outcomes. SLT had developed their own evidence based assessment tool and defined packages of care that could be used for developing and monitoring outcome measures. However, there were no clear measure of patient intervention outcomes or audits at service level, therefore services were unable to demonstrate their services' contribution to patient care.

Services including health visitors and child development centres used the Strengths and Difficulties Questionnaire (SDQ) (a behavioural screening questionnaire) as part of the initial assessment and again at the end of the clinical programme. Although outcomes could be seen on an individual basis, no service audited the questionnaire to demonstrate outcomes at service level or evaluate interventions.

The trust had identified this as an area requiring improvement and therefore, the development of outcomes was registered on the divisional plan for 2014-2015. AHPs told us that they negotiated joint goal setting with children, parents and guardians to ensure treatment was person centred. There was no audit or outcome measure to evaluate the goals at service level.

Performance information

Teams used annual satisfaction surveys and documentation audits to help monitor the service performance, as a result actions plans were completed and these were discussed at team meetings. However, from team meeting minutes we saw that clinical performance data was not regularly discussed within teams throughout children's and families services.

The common assessment framework (CAF) is a national approach to providing a way of assessing children with additional needs, with the purpose to initiate and support early intervention. During 2013-2014 the Commissioning for Quality and Innovation (CQUIN) target of 200 CAFs being initiated by children and families service was exceeded. There were 342 assessments initiated by the division and 265 of those were initiated by the health visitor service.

Competent staff

New staff received a comprehensive induction. Annual appraisal, regular one to ones and clinical supervision were in place. Newly qualified health visitors completed a one year preceptorship programme, with monthly supervision. During 2013-2014 the CQUIN target of 85% of health visitors, family nurses and staff nurses in the health visitor service being trained in the common assessment framework was exceeded at 89%.

Health visitors had 'shut down days', where clinical supervision and discussion of challenging cases took place to share clinical skills and knowledge. Physiotherapy and OT had journal clubs and rotational staff posts, some shared with Birmingham Children's Hospital NHS Foundation Trust (BCH) and others with adult services to ensure staff were competent in a variety of clinical areas.

Some health visitors were completing local and national leadership programmes. Occupational therapists had received funding for five staff to complete sensory integrated training at masters' level despite no sensory integrated service being commissioned.

Use of equipment and facilities

Services were colourful, interactive and a pleasant environment for children and young people. There were good children's facilities within services; including a sensory room at Bacchus Road Child Development Centre. There were multiple in and out door play areas for children across the service catering for different ages and abilities.

Staff told us that they had enough equipment to deliver care and that they had no problems ordering equipment. The OT team reported they had good access to equipment for service users from the local equipment store, and most items were readily available and delivered promptly.

Good

Are Community health services for children, young people and families effective?

Multi-disciplinary working and working with others

Allen's Croft Children's Centre had been chosen to launch the Royal Society for the Prevention of Accidents' first ever Family Safety Week in March 2014. The centre was chosen as an outstanding example of a multi-agency partnership, with early year's education services provided by Birmingham City Council (BCC) alongside specialist paediatric healthcare services delivered by Birmingham Community Healthcare NHS Trust (BCHC) and other NHS colleagues in the dedicated centre.

Allen's Croft Children's Centre also hosted a disabilities awareness day, organised jointly with BCC. Organisations such as Whizz-Kids and Family Fund were also invited to provide a fun family event along with relevant information and support.

The children's SLT service was reviewed by West Midlands Quality Review Service on 8 October 2013. It was reported that all the families and partner organisations who met the visiting team commented on the high quality of care provided by the children's SLT service for individual children and young people. Reviewers were also impressed by the willingness of partners to work with the service and to make their contribution to the development of children's speech, language and communication.

Health visitors told us that care was delayed as multiagency meetings that were difficult to organise due to lack of communication between services and health professionals' limited availability. They told us that they had tried to improve relationships by meeting with social care services but that there continued to be a lack of communication between the services and that this was very time consuming to resolve.

Staff across most services reported difficulties accessing, referring to, and communicating with social services and Child and Adolescent Mental Health Services (CAMHS). They felt this delayed appropriate care. Physiotherapy staff told us that the service had good links with other local services and delivered joint care and treatment with local trusts, such as the Physiotherapy Instrument Mobilisation (PIM) treatment and serial casting.

There were multi-disciplinary group programmes delivered at Bacchus Road CDC involving physiotherapists, SLTs, nursery nurses and OTs, such as children's social communication groups and early development assessment pathways. The emotional health nurse delivered joint consultations with school nurses.

Co-ordinated integrated care pathways

Children's services were dedicated to delivering care as close to home as possible, minimising disruption to the daily life of children and their families. Services were delivered from locations across Birmingham and had good multi-agency engagement. This ensured the provision of care met the needs of children, young people and their families, both from a clinical perspective and also close to home.

There were few transition pathways across children and families services and OTs, physiotherapist and health visitors told us that they had concerns for those young people who were due to transfer into adult services. Some services had started to implement transition arrangements such as a pilot scheme in physiotherapy and joint child and adult clinics in attention-deficit hyperactivity disorder services. One carer we spoke with at the looked after children's centre was unsure what would happen when the young person they cared for turned 18 years.

The local CAMHS was provided by a different provider and staff reported this service now had stricter referral criteria and had declined a number of the trust's referrals. Some delays were reported in referrals to social services due to the capacity and demand on the local authority. Health visitors told us that they had met with social care services to discuss these concerns and improve relationships but that there continued to be a lack of communication between the services and that this was very time consuming to resolve.

Good

Are Community health services for children, young people and families caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

Care and treatment of children and support for their families, was flexible, empathetic, and compassionate. Each child and family's culture, beliefs and values had been taken into account in the planning and delivery of care. The majority of children, young people and their parents and/or guardians we spoke with said they felt involved in the care. The trust promoted self-care to empower children and families.

Detailed findings

Compassionate care

Care and treatment of children and support for their families, within all services was flexible, empathetic, and compassionate. The majority of children, young people and their families were positive in their views of the caring and compassionate nature of staff.

Staff in all services told us that they strived to maintain staff continuity of care for children to help build rapport and trusting relationships. The health visitors we accompanied on home visits were passionate, committed and demonstrated an excellent understanding of the children's needs. Health visitors asked parents and guardians sensitive questions in a delicate fashion and explain why such information was required. They described the care that they were delivering and what support the children, parents and guardians could expect from their service.

The Respite Care Unit at Edgewood Road had care records about children to help staff provide individualised care, such as 'All about me' sheets that discussed the child's needs, preferences and dislikes. We witnessed staff tailor care to meet the individual needs of children. Parents told us that there was constant communication between staff and themselves regarding their child's care and treatment.

Dignity and respect

We witnessed positive interactions between children, parents and staff. Children, young people, their parents and guardians were treated with dignity and respect by staff. Each child and family's culture, beliefs and values had been taken into account in the planning and delivery of care. The trust provided equality and diversity training, and staff told us that they shared learning about cultures and beliefs between peers.

Patient understanding and involvement

Child centred care was delivered and children, young people, their parents and guardians were involved in, understood and central to all decisions made about the care and support needed. We spoke with two parents of children at Allen's Croft Children's Centre, who told us that treatment needs were fully explained by staff, and that they were offered copies of the child's care plans and treatment pathways to keep them informed.

As a result of feedback from the annual satisfaction survey (November 2013-January 2014), physiotherapists had ensured that parents and guardians were invited to appointments at schools to make sure that they were involved in the care of their child. We spoke to two carers at the looked after children's services who told us that the service was good and that the young person they cared for had given consent to ensure that they were kept informed about the care. Health visitors explained to parents what they were documenting in children's 'red books' and negotiating when was convenient for the family to revisit.

Emotional support

The looked after children's service used the Warwick-Edinburgh Mental-Being Scale as a way to measure children's mental wellbeing and provide support. There was an emotional health nurse to support children to promote health and wellbeing of all school age children. They were able to offer six direct sessions with a child to emotionally support the child through matters such as bereavement, self-harm and depression. The emotional health nurse also educated school nurses and children through presentations and workbooks.

Parents told us that they were supported emotionally by staff and that staff had time to discuss concerns they had.

Promotion of self-care

Health visitors supported new parents and were able to offer advice and guidance about different types of services available that they could access for information and support. For example, the attention-deficit hyperactivity

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Are Community health services for children, young people and families caring?

disorder team nurses told us that they worked with children to teach them about the administration of their medication and that this increased compliance and promoted self-care.

Allied health professionals told us that they explained and taught children, parents and guardians about treatment the child required so that the people felt empowered and could safely deliver this treatment at home.

The annual OT satisfaction survey (August-September 2013) showed that 93.75% of parents or carers practiced activities suggested as part of the treatment of the child. One person said, “We practice the activities at home and we could see improvement”. The physiotherapy annual satisfaction survey of young people (November 2013 – January 2014) showed that 90% completed the recommended exercises when the physiotherapist was not present.

Requires Improvement

Are Community health services for children, young people and families responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

Some services failed to meet the 18 week referral to treatment time pathway and children did not receive timely intervention; most notably the occupational therapy and speech and language therapy services.

Children and families services were committed to delivering care as close to home as possible, minimising disruption to the daily life of children and their families. The service planned and delivered health campaigns in partnership with local agencies to meet the needs of the children living in Birmingham, addressing specific conditions where the health of children in Birmingham was worse than the England average.

Staff had a good understanding of the population who used the service and were all able to explain with confidence the requirements of the people they cared for. Interpreter services were readily available and some information was available in different languages.

Children did not have timely access to SLT interventions. There had been over 50 negative comments regarding waiting times, from children and families in the SLT satisfaction survey (November-December 2013). Waiting times had been an on going problem for over 2 years. The trust had recently received funding and a plan was in place to reduce waiting times.

Transition services were poorly managed as there was a lack of arrangements in place for those young people who were due to transfer into adult services. However, there were examples where services had tried to bridge this gap.

There were individual examples where services had learnt from complaints and feedback.

Detailed findings

Service planning and delivery to meet the needs of different people

Birmingham had higher rates of obesity than the England average at 6 years and was in the top 20% of local authorities for obesity for 4-5 and 10-11 year olds. Information was displayed about 'Birmingham children's healthy weight programmes', providing interactive programmes for children aged between 5 to 15 years. Information about healthy lifestyles was displayed in public areas within children's services.

Health campaigns to tackle alcohol misuse were implemented by school nurse students, young people's health advisors and child safeguarding leads; as hospital stays in Birmingham for under 18s were higher than the England average. Workshops took place in schools and we observed health visitors discuss the principles of the 'Who's in Charge?' campaign, which raises awareness of babies and children suffering serious harm after their parents drink too much alcohol at home.

Smoking prevalence in 2009 was 26% amongst 16-19 year olds, higher than the national average and higher than the Birmingham all age prevalence. Stop smoking services worked closely with the Birmingham Health and Wellbeing Board to reduce the number of smokers in the city, increasingly focussing on preventing young people from starting smoking. Smoking among children is declining and evidence shows that if an individual has not taken up smoking by the age of 21, the likelihood of them smoking at all is significantly reduced. By 2014-2015, commissioners had set a target that at least 30% of people accessing the service must be under the age of 30. School nurses had developed training packages for Birmingham schools about how to manage conditions such as diabetes, asthma, epilepsy and the use of emergency medication.

The emotional health nurse only worked during the school term, therefore outside of these dates there was no direct emotional and wellbeing service. The Respite Care Unit at Edgewood Road was open Monday to Friday. Staff told us that there were not enough staff to provide a seven day service and therefore, service users missed out on weekend support.

Access to care as close to home as possible

Children and family services were committed to delivering care as close to home as possible, minimising disruption to the daily life of children and their families. Staff visited people in their own homes or in local centres, schools and nurseries to ensure people were able to access the care they required. There was information available to children,

Requires Improvement

Are Community health services for children, young people and families responsive to people's needs?

parents and guardians regarding access to other services, for example from the local authority. We found that access to the majority of services was good, most were close to main bus routes.

Access to the right care at the right time

The waiting time for an initial SLT assessment were between seven and eight months and there was a further wait of up to 12 months for therapy. Staff told us that they tried to prioritise patients in accordance with patient need; however, this was ineffective due to the long waiting times. The trust had recently received funding which had reduced waiting times from 102 weeks to 48. This continued to fail to meet the 18 week referral to treatment time target. Further funding had recently been agreed on a recurring basis for addition SLT staff to further reduce the waiting times. At the time of our inspection waiting times had reduced to 44 weeks and there were plans to reduce this further to 18 weeks by March 2015. The trusts integrated business plan 2013-2018, estimated 19,600 children were likely to require a specialised SLT service. The SLT satisfaction survey (November-December 2013) had over 50 comments from respondents regarding the long waiting times. Waiting times had been an on going problem for over 2 years; a recent trust plan had been devised that aimed to condense waiting times. Contrary to NICE guidance, SLT input to the diagnostic process for children aged over five with possible Autistic Spectrum Disorder was not commissioned.

Data on the number of children and young people who did not attend (DNA) their booked appointment showed that the average overall service rate was 6.25% between June 2013 and May 2014. This had reduced from 8.6% in April 2012, this indicated that there was better utilisation of staff time and that care could be delivered at the right time. School nursing and health visitors had the highest DNA rates across the service. Health visitors told us that there was a lack of administration within the service, so they tried to arrange appointments themselves to ensure access to care for families was at times that suited them. Staff confirmed appointments with families nearer to arranged dates to prevent DNAs; this was time consuming for clinical staff and diverted them from clinical work. At Bacchus Road CDC they did not hold a DNA list as they felt due to the special nature of assessments few families DNA appointments.

At Bacchus Road Child Development Centre the manager told us that the waiting time had been reduced from 12 months, although the current waiting list we saw showed that there were 33 children waiting for social communication groups. There was a 14 week wait for global development assessments and a 2 week wait for early developmental assessments and intervention pathway.

Occupational therapy had reduced waiting times from 52 weeks and now offered appointment by 37 weeks. In May 2014 there were 151 children waiting for over 18 weeks for an appointment, 75 of these had not yet been offered an appointment. This improvement was a result of the implementation of occasional Saturday clinics, offering staff overtime and the employment of locums. There were three locums working in the service during our inspection, one had been with the service for 18 months, yet we were told no plans were in place to recruit permanent staff.

Flexible community services

There was a monthly late night drop in health visitor clinic for parents and children at Hodge Hill Primary Care Centre which provided greater flexibility for children and their parents. Information on services was available for children and their families on services they could access, and staff in the looked after children's services provided Quick Response (QR) codes for children and young people to access information about the service in the form of an animated "You Tube" video produced by the service.

Meeting the needs of individuals

The staff we spoke with had a good understanding of the population who used the service and were all able to explain with confidence the requirements of the people they cared for. Staff told us that there were about 70 different languages spoken in the local area. Interpreter services were readily available if needed; staff told us that they avoided using family members to help translate and always booked interpreters to ensure accurate information was exchanged. There was an in-house team of interpreters and the Birmingham Integrated Language and Communication Service (BILCS) available for all languages (including British Sign Language) to provide an interpreter service.

There were some information leaflets in different languages and staff told us that they explained leaflets in case people were unable to read. We observed this during

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our inspection. Staff told us that immunisation letters to families could also be written in different languages to help children, parents and guardians understand the reasons for children to receive immunisation injections.

We noticed that there were Induction Loop Systems fitted at the main reception to help patients with hearing impairments.

Support for children with long term conditions was shared with other agencies to ensure a multidisciplinary approach that was based on individual needs. We spoke with the parents of two children with long term conditions at Allen's Croft Children's Centre, who told us that all condition specific referrals had been made by the centre to services, such as OT and physiotherapy. They told us that staff were fully aware of their child's individual conditions and needs and were happy with the care provided.

Moving between services

Staff told us that most children and families services did not have a transition pathway in place for those young people who were due to transfer into adult services. Staff told us that the transition was poorly managed; young people, parents and guardians often were anxious about this transition and this often resulted in reduced healthcare professional contact. One carer we spoke with at the looked after children's centre was unsure what would happen when the young person they cared for turned 18 years.

Some services however, did have transition plans in place such as the children's attention-deficit hyperactivity disorder team nurses who contacted the adult attention-deficit hyperactivity disorder service to arrange joint clinics, allowing initial adult assessments to be made. Physiotherapy services were completing a pilot scheme that supported young people before and during the transition into adult services. The results of the pilot scheme were to be reviewed in September 2014.

Complaints handling and learning from feedback

We saw literature about the complaints procedure and Patient Advice and Liaison Service (PALS) on display at services. There were individual examples where services had learnt from complaints and feedback. For example after a parent complained, the attention-deficit hyperactivity disorder team nurses team had developed leaflets explaining what would happen and the assessment tool used within their service.

The looked after children's service had a touch screen questionnaire, designed by 1000 children and young people in Birmingham schools, for children to complete. Feedback from this showed that children did not know what to expect when coming to the service. As a result the service added a Quick Response Code to the information children receive prior to assessments, this meant that children could access via electronic devices information about the service.

Good

Are Community health services for children, young people and families well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

Children and families services were well led at local level. Staff were passionate and proud about the care they provided, there was clear peer support and they felt supported by their managers. We saw committed leadership and management within individual services However; staff were confused about management structure above their individual service and had little direct contact with the trust board.

There was a robust governance framework and responsibility structure, there were risk registers but staff at service level were unaware of these. There was not significant awareness of clinical governance within services or knowledge of auditing and quality measurement of pathways. There was a lack of clinical research and audit across the service.

Public feedback was collected annually for individual services and actions put in place to improve services for children, young people and their families.

Several children and families services had won awards for practice and innovation, most notably the multi-agency team at Allen's Croft Children's Centre received the Nursing Times award for partnership working.

Detailed findings

Vision and strategy for this service

There was a trust children and families integrated business plan for 2013-2018, which set out the plans for children and families services, in the context of the trust's objectives and on going commissioning negotiations. Most staff were aware of the trusts vision and values as they were part of their appraisal.

There was not a clear management structure within the service. Staff told us that they knew who their immediate line manager was, but were confused about the management structure above their individual service level. Some teams felt there was no future plan for their service and that they were not consulted when changes such as location moves were announced.

Guidance, risk management and quality measurement

The provider was found to be compliant with the NHS Litigation Authority's risk management standards at level 1, meaning that the process for managing risks had been described and documented. The trust's documents were compliant in all area with the risk management standards. There was a clinical quality, safety and governance strategy for 2012-2014, and a robust governance framework and responsibility structure; however, service level staff were unaware of this structure.

Clinical governance was discussed at some management meetings. There were clinical care pathways implemented across children and families services.

Consultant community paediatricians' committee meeting minutes showed attendance at divisional audit days and clinical effectiveness meetings. However, no staff group told us about these governance meetings and some staff we spoke with did not understand the term clinical governance.

Some senior staff were unaware of a service risk register and therefore, we were unable to collaborate if risks to the delivery of high quality care were identified, analysed and actions put into place at service level.

Leadership of this service

We saw committed leadership and management at service level and staff told us they were well supported by their managers. Generally information from the board and senior managers was cascaded to staff via regular email messages and team meetings.

Staff told us that they had little direct contact with the trust board and felt that the board did not understand issues at service level. However, staff at the looked after children's services explained that the chief executive had recently visited the service to bring toys for the children. Most staff appreciated the chief executives monthly blog.

Staff felt supported by their immediate managers and told us that managers often helped with 'frontline' work. With the exception of the attention-deficit hyperactivity disorder team nurses, who told us that they had had no line

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Are Community health services for children, young people and families well-led?

manager for over 12 months and although they received appraisal they had no regular one to ones or team development sessions. Three managers told us that they had completed or were enrolled on leadership courses.

Culture within this service

Staff were passionate about the care they provided. The 2013 staff survey showed that 72% of staff were enthusiastic about their job. There was clear peer support within the service. All staff told us that they were proud of their teams.

We spoke with managers who told us that they were proud of the staff working in children and young people's services and their commitment.

Staff sickness absence rates at the trust were above the average for community provider trusts in 2012-2013. Sickness absence for children and young people's services averaged 4.91% for June 2013 to May 2014; this was below the trusts average of 5.21%.

Some staff felt that the trust was driven by financial targets rather than patient outcome. In the 2013 staff survey 65% of staff agreed that care of patients was the organisations top priority, 17% disagreed.

Public and staff engagement

Public feedback was collected for individual services. The community children's nurses collected feedback which demonstrated that 89% of service users were likely or extremely likely to recommend the service to friends and family and that 68% felt the service they received was excellent. The SLT service collected feedback between November and December 2013. It demonstrated that 81% of services users were likely or extremely likely to recommend the service to friends and family, however there were multiple negative comments regarding the waiting time for appointments.

The attention-deficit hyperactivity disorder service collected face to face feedback from young people, parents and carers between November and December 2013.

Twenty three young people completed the survey that showed 78% were likely or extremely likely to recommend the service to friends and family and 96% rated the service as good, very good or excellent. Each of the 28 parents and carers respondents said they were likely or extremely likely to recommend the service to friends and family.

The trust had begun a 'Patient Experience Forum'. The role of the forum was to examine, discuss and challenge, members' experience, reports and information the trust has on patient experience; this engaged patients, and their carers on the forum.

Trust wide net promoter values (data collected from the Family and Friends test which asked patients and their families if they would recommend services to the relatives) increased from 68 (January/February 2014) to 78 in March/April 2014. The percentage of patients reporting overall satisfaction (very good/excellent) increased very slightly from 80.53 to 81.07% during this period.

There was a staff survey in 2013 with an associated action plan for improvements that encouraged staff to be part of local development. There was a weekly trust e-newsletter and monthly newspaper to keep staff informed about recent trust news and information reminders about matters such as dignity and safeguarding. However, there was a lack of belonging to the trust from some staff within services.

Innovation, improvement and sustainability

Staff told us about the trusts Values in Practice (VIP) awards and how these recognised innovative and dedicated practice. The complex care team at Barbara Hart House had won an award for 'quality and innovation' with the VIP awards in July 2013.

The multi-agency team at Allen's Croft Children's Centre received a Nursing Times award for partnership working; and health visitors had been a pilot service for the Ages & Stages Questionnaires (ASQ), a developmental and social-emotional screening for children.