

Sandwell and West Birmingham Hospitals NHS Trust

RXK10

RXK21

RXK27

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 Sandwell and West Birmingham Hospitals NHS Trust. 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 Sandwell and West Birmingham Hospitals NHS Trust and these are brought together to inform our overall judgement of Sandwell and West Birmingham Hospitals NHS Trust

Summary of findings

Ratings

Overall rating for Community health services for adults

Not sufficient evidence to rate



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

Not sufficient evidence to rate



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

Not sufficient evidence to rate



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

Not sufficient evidence to rate



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

Not sufficient evidence to rate



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

Not sufficient evidence to rate



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
Background to the service	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the provider say	6
Good practice	6
Areas for improvement	6

Detailed findings from this inspection

Findings by our five questions	7
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Summary of findings

Overall summary

During this inspection we have reviewed all of the domains but we have insufficient evidence to rate this service. It is our intention to return and undertake a focussed inspection within six months.

We visited a number of children's services that included specialist nursing services, therapy services, community paediatric services for children and families in vulnerable

circumstances, and the young person's sexual health service, across a variety of community locations. We visited a school for children with special needs and a primary school that catered for a number of children with special health needs. We observed therapies being delivered.

Summary of findings

Background to the service

While we found some of the children's and young people's services provided by Sandwell and West Birmingham Hospitals NHS Trust services requiring improvement and we found evidence of outstanding practice in others.

Poor communication between staff teams and GPs, due to the numerous integrated technology (IT) systems used, poor staffing levels and lack of management feedback, had been reported to us in some areas. All staff told us that incident reporting was encouraged. However, in some areas staff told us they had received very little feedback from the trust, and that learning from incidents was not always shared with them.

Medical and staffing levels met the assessed care and treatment needs of children and young people in most areas. Staff in other areas told us they had been submitting incident forms for over a year, stating that staffing levels were unacceptably dangerous, but without any response from the trust or extra staff being provided. However the trust leadership disputed this saying they had not received any incident forms stating dangerous staffing levels.

The standard of cleanliness and the control of infection within all children's clinical areas were monitored, and staff complied with the hospitals' policies and procedures promoting the control of infection.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing & Quality, Kent Community Health NHS Trust.

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: a community matron, a district nurse, a therapist 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

We inspected this core service as part of our Comprehensive wave 3 Combined Acute and Community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out

announced visits on 15, 16 and 17 October 2014. During the visit we held focus groups and interviews with a range of staff who worked within the service, such as palliative care nurse specialists, district nurses, nurses, healthcare assistants and senior clinicians. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider say

Most people using the service told us they were receiving a good standard of care supplied by caring and friendly staff. A parent of a 9-week-old baby showing a failure to thrive told us, "I have no family so the health visitor and team help me to cope. Their support has been excellent."

A mother expecting her fifth baby told us, "I have had no problems with the handover of care between my

midwives and health visitors. There have been no gaps in my care at all. I received very good breastfeeding advice in hospital with my first baby and now just know what to do. I am very happy."

A parent whose child was receiving interim community care told us, "The support I have received has been excellent. I would not be able to cope without the nursing team."

Good practice

Within the Lyng and Victoria health clinics. Staff supported children and parents with clear explanations of treatment, appropriate to their levels of understanding,

before delivering the treatment. One person, who had moved away and was living out of area, continued to attend the clinic with their child because they felt the care was worth travelling for.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Sandwell and West Birmingham Hospitals NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Not sufficient evidence to rate

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

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

By safe, we mean that people are protected from abuse

Summary

Incident report writing was encouraged by the trust; however staff were discouraged to do so because of the lack of feedback or any changes being made as a result. The trust was aware of child sexual exploitation and had robust systems to raise concerns. We saw good examples of safety referrals between midwives and health visitors via 'Cause for Concern' forms.

Incidents, reporting and learning

- There had been no recent 'never events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers) reported over the past 12 months within the directorate.
- Staff were raising concerns through the hospital's electronic reporting system and by completing the 'Your

voice' questionnaires. Although incident report writing was encouraged by the trust, some staff told us they felt discouraged to do so because of the lack of feedback or any changes being made as a result.

Staffing levels and caseload

- There was a new health visitor initiative to visit all pregnant women with a midwife between 20 and 28 weeks' gestation to pick up any extra care, support or input that may be needed postnatal (for example, interpreters, information in different languages or education for new mothers). Access to the home or any domestic issues that might affect the visit could also be assessed and alternative arrangements made.
- The midwifery matron told us that sickness levels were high within the midwifery service and staff who had left had not been replaced at the time of our inspection. We

saw evidence of this in the trust's staff sickness and staff turnover record for the past 12 months. The rates of sickness and turnover among registered nurses and midwives were the highest within the trust, ranging from 2.8% sickness in May 2013 to 10.2% in November 2013. The latest figure printed for July 2014 was 5.36% for sickness. Nurse or midwife turnover for 2013/14 was 3.81% compared with 2.11% in 2012/13. However, we were advised that this was having no impact on the delivery of care because staff had been covering the service internally.

- Health visitors at the focus group told us that their national recruitment drive needed 40–80 new whole time equivalent posts; however, health visiting staff we talked to thought that more than these would be required. The trust later informed us they would reach establishment by March 2015.
- We were told that human resources had been taking so long to do the background checks on newly recruited staff that two out of the last three staff employed had found other jobs.

Records systems and management

- We observed staff using paper notes with children's identifiable information on them being used in communal areas. There were also no reception staff at either clinic, or locked doors. This raised confidentiality issues which were raised. Health visiting staff told us they were aware of these issues and were using Ziploc® bags when taking notes from clinic to clinic. They were also trialling 'paper-light' and 'paperless' systems.

Safeguarding

- We saw and raised safeguarding concerns for children being accommodated in unacceptable and unsafe conditions at a hostel for families waiting for 'leave to stay' and for mothers fleeing domestic violence or abuse. Although the trust was not responsible for placing parents and children in the hostel, trust staff were required to visit and had a duty of care to report safeguarding issues. Systems were in place to enable

them to do that via the trust own safeguarding policies. One mother had stayed in there for 3 years. All the parents we spoke to said the health visitors were excellent, and they did not know what they would do without support from the service. We were informed by the trust that all the staff working at the hostel had undergone Disclosure and Barring Service (DBS) checks undertaken by the local authority.

- The trust was aware of child sexual exploitation and had robust systems to raise concerns.
- The chief nurse and safeguarding lead were responsive to the escalation of safeguarding issues. However, they told us that the safeguarding policy was not as robust as it should be, and that the safeguarding of children was not embedded across the organisation.
- There were good examples seen of safety referral between midwives and health visitors via Cause for Concern forms, which, once generated, were sent automatically to health visitors, GPs, and safeguarding and children's services. Multi-agency referral forms (MARFs) were sent to social services' Multi-Agency Safeguarding Hub (MASH). We were advised of an example where a young parent had concealed their drug addiction; however, their behaviour had led to a Cause for Concern form being triggered. All service providers, including the GP and drug worker, who were unaware of the pregnancy were informed. With thus multidisciplinary approach, the parent received the help they needed, became drug free and was able to keep their baby.
- We were advised by a senior member of the team for children's and young people's services that about 90% of staff had attained level 3 safeguarding training, and 70% level 2. Level 1 safeguarding training was being reviewed on the initiative of a senior member of the team because of concern that it offered an insufficient level of knowledge to meet the requirement.
- At the Lyng and Victoria health clinics, all staff seen had attained level 3 safeguarding. Good generic and personal risk assessments for particular incidents were seen.

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 care and treatment provided were based on national guidelines and directives. Policies and procedures were reviewed regularly and updated as necessary. Audits took place within the trust to monitor the care and treatment delivered to children and young people, and actions were identified to improve practice.

Evidence based care and treatment

- A senior member of the team for children's and young people's services told us there were monthly performance and quality meetings to discuss all specialties including quality performance targets. Although invited, we did not see evidence of this taking place. We saw excellent examples of multidisciplinary team working at the Lyng and Victoria health clinics. There was good communication between staff across the organisation. Staff told us the trust had been proactive in recruiting staff in line with national and local initiatives. The health visitor strategy implementation plan was in place and the trust had employed an extra 17 staff in the current financial year because of it. Due to a national specification means that services were being changed. Health visitors told us that they would now be involved in antenatal visits, which would put a future strain on their newly gained resources. We were also advised that the trust was redeploying healthcare assistants equating to 63 hours to administration roles. We were told by staff that this too would place further pressures on nursing resources.
- One mother told us that she had received a visit from a health visitor and a nursery nurse at the same time, so that her toddler could be looked after and her baby have the routine postnatal checks without going to the clinic. However, from the evidence available, it was not clear if this was a special case.
- Sexual health services for children and young adults used local and hospital data in relation to clinical decision making, and staff understood their roles and responsibilities within the sexual health remit.

Use of technology and telemedicine

- We witnessed very good multidisciplinary team working practices at both clinics with good verbal communication between midwives and health visitors. However, health visitors could not access the midwives' new IT system 'Badger Net' from their IT system, 'SystmOne', which was an electronic patient record system. This was having an impact on time resources because of extra paperwork and telephone calls to try and access information. The GPs used three IT systems: 'SystmOne', 'EMIS' and 'Synergy'. All staff said that, although they liked their individual systems, an integrated one that everyone could access would save a great deal of time and resources.
- We were advised by staff at the focus group that all patients had two unique hospital numbers: an NHS/RXK number and a National Health number. Most staff said that looking up patient information was taking time, and causing frustration and confusion; their view was that there should be one universal hospital number.
- Following the inspection the trust clarified that all patients have two unique numbers once they have been admitted to hospital, which is different from the NHS number.
- Staff advised us that obtaining equipment for children could be delayed or not provided when families lived outside of the area and were registered with a GP in the Sandwell area.

Multi-disciplinary working and coordination of care pathways

- There was an excellent example seen of multidisciplinary team working within the children's therapy team. A young person with an end of life care plan was able to be cared for at home. The teams set up 'clinical care competencies' to continually educate other members of staff, and team members worked closely with the children's hospice to facilitate the child's care. Children's therapies had been awarded the 'Beacon Services Award' for innovations in practice.

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

Competent staff

- Annual appraisals and development planning for staff were noted to be in place. Trust figures stated that appraisals figures were 100% for 2013/14, an improvement on 72% in 2012/13.

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

Patients and their families or carers were generally treated with dignity and respect. Surveys took place to gather feedback from patients, their families and carers.

Communication and information sharing were generally perceived as good by children, young people and families we spoke with. Parents, carers and their children were able to ask medical and nursing staff questions about their care and treatment. Written and verbal information were provided.

Compassionate care

- The children's therapy teams at Orchard and Crocketts Schools were observed talking to children and their families or carers. Staff were gaining children's trust to facilitate treatments and therapies. We observed families working with the carers and therapists in a cohesive and relaxed way, with easy conversation between all parties.

Dignity and respect

- We saw midwives treating people with dignity and respect. Most of the mothers told us in person and via telephone interviews that they felt well supported by kind and caring midwives and health visitors. We were told by one parent that "the health visitors are working over and above and have helped to change my life".

Patient understanding and involvement

- We saw excellent caring staff at the Lyng and Victoria health clinics. Staff were observed giving children and parents clear explanations of treatment, appropriate to their levels of understanding, before delivering the treatment. One person, who had moved away and was living out of area, continued to attend the clinic with their child because they felt the care was worth travelling for.

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

Procedures were in place and ensured the flow of patients through the service. This benefited children and young people because appropriate treatment and care were provided in a timely way. Discharge planning was effective. It included the parents or carers and professionals who would support the children and young people at home.

The service was designed to meet the needs of all children, including those with extra needs. Interpretation services were available when required and accessed in most cases. Care and treatment from specialist services were accessed when necessary (for example, from the diabetic and podiatry teams).

Service planning and delivery to meet the needs of different people

- Acute and community teams were on different computer systems so there was a concern that some children's needs could be overlooked. This also applied to adults. It was being looked into at trust, clinical commissioning group (CCG) and local authority level.
- There was evidence that both teams at Orchard and Crocketts Schools were offering effective family- and child-centred work. Therapists were observed working with parents to educate them on how to provide therapy, as well as giving advice. We saw individualised care and treatment plans where parents and carers were able to make comments and suggestions (for example, 'What worked well and what did not work well'). Therapists were seen offering practical and emotional support to both children and parents in a natural and unhurried way. We saw multi-agency surveys for parents and carers.

Access to the right care at the right time

- We saw very good use of face-to-face interpreters across all areas inspected. The trust had a policy of not using family members or children to interpret for adults. We saw evidence of the trust meeting cultural needs: for example, via pictorial information leaflets, signage in a

variety of languages and multilingual staff. However, health visitors told us there had been a few incidents when midwives had not told them during handover that the mother was non-English speaking. The clinics clearly reflected a range of values and cultures, and held conferences to discuss vulnerable families.

- Sexual health clinics ran a 6-week sexual health course for clients including young people. Literature was available in a variety of languages on 'self-empowerment'.
- Crocketts Community Primary School had attained a service level agreement with the local authority to cater for children with special health needs. At the time of our inspection, they were delivering mainstream education to three children with tracheostomies and others on long-term ventilation and or with profound mobility problems. One child told us, "I am so happy to be here. I am very clever and didn't like it at my special school."

Complaints handling (for this service) and learning from feedback

- Staff working in the community told us their complaints and concerns were listened to and improvements had been made as a result. For example, they told their manager that some of them did not understand the technology around 'Badger Net', the new (IT) recording system which was also used within midwifery. Further training was therefore arranged and subsequently made mandatory.
- Some mothers told us their only complaint was that midwives could only give them a specific day when they could visit, not a specific time. This had led to missed appointments because mothers with other young children could seldom wait in all day. Mothers told us that health visitors were able to offer them morning or afternoon appointments, which made it a lot easier for them. Midwives told us they were aware of the situation and were looking into ways of improving it whenever possible.

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

Many staff were positive about the leadership and management of the Community Children's directorate. The culture appeared to be open and staff were able to discuss any concerns or raise incidents. Staff also told us that often concerns they had raised had not been acted on.

Governance, risk management and quality measurement

- A senior member of the team for children's and young people's services told us there were good governance arrangements with clear escalation procedures.

Leadership of this service

- There was a good local managerial structure and strong interpersonal relationships seen at the Lyng and Victoria health clinics. There was also strong staff awareness of the management structure.
- Therapy staff at both schools received good and accessible mandatory training. We were told that this was currently acute or adult based, but that managers were aware of this and trying to make the training more child focused. Staff also said they had a good knowledge of the management structure and always had a good managerial response to their needs. One staff member told us, "We have an outstanding manager."

Public and staff engagement

- Senior management sought and acted upon feedback from staff and service users regarding the health visiting initiative 'which aims to increase health visitor numbers in the city by 2015 and aims to deliver a consistently high quality service to all new mothers and their children'. Both midwives and health visitors shared their views about workload in particular regarding the health visitor initiative of joint antenatal visits to women between 20 and 28 weeks' gestation. The matron had listened and raised them with the senior management in relation to the impact on workforce capacity. However, some staff told us they feared reprisals for raising and reporting issues, and they also feared for their jobs.

Innovation, improvement and sustainability

- We saw some examples of improvements to service and changes made as a result of feedback. For example, school therapists had made a case for mobile phones via 'Your voice', and they were successful in obtaining these. However, the community children's nurses had been raising concerns about the risks of carrying confidential notes. They had made many application attempts to be included on 'SystemOne', but had been unsuccessful. However the trust informed us they would have access in 2015.