Birmingham Women's and Children's NHS Foundation Trust

Inspection report

Birmingham Children's Hospital
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Date of inspection visit: 21, 22, 23 June 2022, 25 and 26 July 2022, 9 and 10 August 2022, 10 and 11 October 2022.
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Birmingham Women's and Children's NHS Foundation Trust is responsible for managing Birmingham Women's Hospital, Birmingham Children's Hospital and Forward Thinking Birmingham. It was created by a merger of Birmingham Women's NHS Foundation Trust with Birmingham Children's Hospital NHS Foundation Trust in February 2017.

The trust is one of five trusts within the Birmingham and Solihull Integrated Care System. It has an annual turnover of £535 million, and provides a range of general and specialised services, including tier 4 Children's and Young Persons mental health services to young people up to the age of 25 years.

Birmingham Women's Hospital provides specialist services to more than 50,000 women, men and their families every year from the city, the wider region and beyond. One of two dedicated women's hospitals in the UK, the maternity unit delivering more than 8,200 babies a year. The hospital offers a full range of gynaecological, maternity and neonatal care. The fetal medicine centre receives regional and national referrals and is home to the West Midlands Regional Genetics Laboratory.

Birmingham Children's Hospital is a specialist paediatric centre, caring for sick children and young people up to the age of 16. The hospital has a national liver and small bowel transplant centre. They are a nationally designated specialist centre for epilepsy surgery and host a paediatric major trauma centre for the West Midlands. Alongside a Paediatric Intensive Care Unit.

Forward Thinking Birmingham is one of the largest Child and Adolescent Mental Health Services in England, with a dedicated inpatient eating disorder unit and acute assessment unit for regional referrals of children and young people with the most serious of problems (Tier 4), and the Forward Thinking Birmingham community mental health service for 0-25 year olds.

Between 21 June 2022 and 11 October 2022, we carried out an unannounced inspection of two of the acute and the three mental health services provided by this trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall.

Our findings

We inspected critical care and surgery at Birmingham Children's Hospital and specialist community mental health services for children and young people, child and adolescent mental health wards and mental health crisis services and health-based places of safety; all part of Forward Thinking Birmingham. We inspected these services as our intelligence suggested there may have been a deterioration in the safety and quality of care provided.

Following this inspection, due to concerns found within the specialist community mental health services and on the child and adolescent mental health wards, we issued the trust with a Letter of Intent to take urgent enforcement action if significant improvement was not made. The trust took action and we received initial assurances that improvements were being made. We revisited the services between 10 and 11 October 2022 and found that significant improvement was still required in the quality of healthcare relating to management of risk due to issues with records.

We did not inspect any other services at Birmingham Children's Hospital or Birmingham Women's Hospital because our monitoring process had not highlighted any concerns. We will re-inspect these services as appropriate.

NHS England System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes: quality of care, access and outcomes, preventing ill health and reducing inequalities, finance and use of resources, people and leadership and capability.

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. As of April 2022, the trust's segmentation was 2.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed 'is this organisation well-led'. We inspected the well-led key question between 9 and 10 August 2022. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England. There was not a separate 'Use of Resources' assessment in advance of this inspection.

Our rating of services went down. We rated them as requires improvement because:

- We rated, safe, responsive and well-led as requires improvement and effective and caring as good.
- In rating the trust, we took into account the current ratings of services not inspected this time.
- Services that formed part of Forward-Thinking Birmingham (FTB) did not always provide safe care. FTB services did not always have enough nursing staff and support staff to keep patients safe.
- In the acute surgery services, staff did not always ensure that risks associated with the environment and equipment were consistently mitigated. Care records were not always stored securely ensuring personal and sensitive information was protected. The service did not always ensure safe systems were followed to prescribe, administer and store medicines. Children, young people and their families' individual care preferences were not always recorded to show these had been assessed and responded to.
- In acute and FTB services, action was not always taken to ensure risk assessments and risk management plans were consistently recorded for all relevant aspects of care and treatment. When risk assessments and management plans were in place, they were not always updated in response to changes to children and young people's care needs.
- Not all staff in FTB services worked well together for the benefit of patients. Staff did not always work well with the psychiatric liaison team, who often referred adults to the crisis service.

Our findings

- Staff in FTB services did not always understand the individual needs of children and young people who used the service. They did not always actively involve children, young people and their families in care decisions.
- In specialist community mental health services for children and young people, children and young people sometimes had to wait long periods of time for their treatment.
- The FTB service was not well led, governance processes did not ensure that procedures relating to the work of the service ran smoothly.
- In FTB services, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

However:

- The acute services had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Services controlled infection risk well. Staff in the paediatric intensive care unit (PICU) assessed risks to patients, acted on them and kept good care records. PICU staff managed medicines well. Services managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers mostly monitored the effectiveness of services and made sure staff were competent. Most staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff in the acute services treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Most services planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed.
- Leaders ran acute services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Services engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.
- The trust collected reliable data and analysed it. In acute services, staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

How we carried out the inspection

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

What people who use mental health services say

Children and young people who used the mental health services told us they did not have a care plan and information about their treatment was not explained to them.

Our findings

Children and young people said there were not enough staff and the staff member supporting them often changed. They said their appointments were cancelled due to staffing or they did not run to time. Children and young people said face to face appointments were not offered freely even if it is a preference.

Children and young people said access into the service needed to improve as they waited too long which often resulted in them reaching a crisis point. One person said they only received help after they had been in crisis and went to the local emergency department. People said they waited a long time to see the doctor.

Children and young people said they did not receive feedback about complaints they had made, other people did not know how to make a complaint and some people did not feel listened to.

However:

A relative said they and their family felt listened to and were involved.

Some children and young people said staff were responsive and answered any questions they had, were lovely, polite and respectful. People said the care coordinators were consistently great. They told us that they had waited a long time but once they received the care it was very good, and they would be lost without the support they received.

Children and young people said the service was passionate about patient voice and co-production.

They said there was effective signposting to other services and charities and therapy and counselling sessions were very helpful.

Outstanding practice

We found the following outstanding practice:

Trust Wide

- Stop. Challenge. Change: The tool provided staff with a confidential way to report any incidents of discrimination, harassment or bullying that they experience or witness. The tool could also be used to share experiences or raise general concerns and observations.
- The trust had established and developed the role of an inclusion ambassador across the trust to support staff to raise concerns ensuring their voice was heard.

Birmingham Children's Hospital

Critical Care

- The critical care outreach team facilitated discharge directly from PICU for patients with complex health conditions.
- The tech team provided a bespoke service which supported the service and enabled nursing staff to focus on their patients.
- Quality improvement and safety teams carried out comprehensive research, training and provided development opportunities for all staff.

Our findings

- Staff from all disciplines worked very closely to jointly agree on the care and treatment of patients with specific focus on each individual's needs and those of their parents/carers.
- The chaplaincy service networked internationally as well as locally and nationally to continually build upon the support that they provide for patients and families and worked innovatively to inclusive and provide bespoke support.

Surgery

- Theatre staff and surgeons were trialling and implementing High Intensity Throughput Theatre (HITT) lists to aid recovery of surgical referral to treatment times post pandemic. A HITT trail in Urology showed that theatre utilisation increased from 40%-54% to 74% and 86%. Managers were learning from the successful introduction of HIIT lists and were applying learning to other clinical specialties or theatres.
- Innovative surgical procedures were developed at the service. For example, this service was the only service in the UK offering augmented reality paediatric surgery for tumour resection and bowel surgery. Augmented reality surgery involves using a fluorescent dye and near infrared cameras to be able to give a different view during surgery. Using this technique gave children and young people better surgical outcomes.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with six legal requirements. This action related to four services.

Trust wide

- The trust must have systems and processes in place which are operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users in Forward Thinking Birmingham. Regulation 17: Good governance.

Birmingham Children's Hospital

Surgery

- The trust must ensure that risks associated with the environment and equipment are consistently assessed and reviewed and that appropriate plans are in place to mitigate any risk of harm. This includes the risks associated with the use of bed rails. Regulation 12: Safe care and treatment.
- The trust must ensure care records are stored securely to consistently ensure children, young people and their families personal and sensitive information is protected. Regulation 17: Good governance.
- The trust must ensure that the trust's policy on the safe prescription of medicines is consistently followed. Regulation 12: Safe care and treatment.

Our findings

Forward Thinking Birmingham

Specialist community mental health services for children and young people

- The trust must ensure that staff assess, document and update patient risk assessments in a timely manner. Regulation 12: Safe care and treatment.
- The trust must ensure all incidents are reviewed in a timely manner and that appropriate actions are subsequently taken to mitigate risk. Regulation 12: Safe care and treatment.
- The trust must ensure the review of incidents are followed up to ensure all identified risks have been addressed through risk assessment and care planning and that any actions agreed and learning from incidents are implemented. Regulation 12: Safe care and treatment.
- The trust must ensure that staff make safeguarding referrals when required to ensure they safeguard children and young people from abuse and harm. Regulation 13: Safeguarding.
- The trust must ensure that all staff are compliant with their mandatory training. Regulation 18: Staffing.
- The trust must ensure that all young people are offered a copy of their care plan. Regulation 9: Person centred care.
- The trust must ensure that governance systems are effective in identifying concerns related to patient risk assessment and risk management. Regulation 17: Good governance.
- The trust must continue to ensure that people who use the service are not ‘lost to follow up’ and staff follow up people who do not attend appointments. Regulation 12: Safe care and treatment.
- The trust must ensure that waiting lists are reduced so that people receive care and treatment in a timely manner. Regulation 17: Good governance.

Child and adolescent mental health wards

- The trust must ensure that environmental risk assessments are undertaken and updated to reflect any risks present. Regulation 12: Safe care and treatment.
- The trusts must ensure that wards are clean, well maintained and safe for use. Regulation 15: Premises and equipment.
- The trust must ensure that it maintains an accurate, clear and contemporaneous record of care and treatment. Medication cards must contain all information required, including mental health act status, for staff to deliver safe and effective care. Regulation 17: Good governance.
- The trust must ensure that it assesses, monitors and improves the quality and safety of the services provided in the carrying out of a regulated activity. Audits and quality improvement processes must ensure that any failings are identified, mitigated and reviewed by managers to ensure compliance with regulations. Regulation 17: Good governance.

Mental health crisis services and health-based places of safety

- The trust must ensure that it continues to monitor and adjust staffing levels as needed to ensure that there are enough staff to respond to urgent referrals. Regulation 18: Staffing.

Our findings

- The trust must ensure that they work with external teams and partners across the urgent care system to ensure the risks relating to the health, safety and welfare of service users are assessed and reduced. Regulation 17: Good governance.

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure mechanisms are in place for providing staff, in corporate services and the mental health division, with the development they need, including high-quality appraisal and career development conversations.

Birmingham Children's Hospital

Surgery

- The trust should ensure plans to increase training continue, to enable staff to effectively support children and young people who live with a learning disability and/or mental health condition.
- The trust should ensure there is a focus on addressing identified mandatory training gaps.
- The trust should ensure they continue to look at improving storage facilities on ward 10 to promote a safe environment.
- The trust should ensure they continue to make progress with their post Covid recovery plan.
- The trust should consider how to improve the efficacy of clinical audits to ensure the concerns relating to the Regulatory breaches listed above are addressed and improvement is maintained.
- The trust should consider how to improve the recording of children and young people's preferences in care records to promote person centred care.

Forward Thinking Birmingham

Specialist community mental health services for children and young people

- The trust should ensure that medical equipment is in date and when reaches its expiry date staff dispose of it.
- The trust should ensure that weighing scales are calibrated regularly to ensure they are safe to use.
- The trust should ensure that the effects of prescribed medicines on patient's physical health are regularly monitored to ensure their safety and wellbeing.
- The trust should ensure that in areas where patients are seen ligature cutters are provided and staff know how to use them.
- The trust should ensure that staff complete cleaning records to show that areas where patients are seen are clean and safe.
- The trust should ensure that they record their response to concerns and complaints.
- The trust should ensure that they continue to explore alternative accommodation that will consider the needs of all people who use the service.
- The trust should ensure that all information about the service, how to complain and about treatment and care is provided in accessible formats to people who use the service.

Our findings

- The trust should ensure that audits are effective in assessing and identifying risk.
- The trust should consider the needs of children and young people who use the service and provide facilities to meet their needs while waiting for an appointment.

Child and adolescent mental health wards

- The trust should ensure that all information held in patients' notes are complete and contain all relevant information.

Mental health crisis services and health-based places of safety

- The trust should ensure that patients are always offered a copy of their care plan.
- The trust should ensure that staff understand and respond appropriately to patients' communication needs.
- The trust should ensure that staff complete regular physical health monitoring for patients who require this and that they record evidence of this in patient records.
- The trust should ensure staff receive regular supervision that meets their individual needs, in line with policy.
- The trust should ensure they are able to provide staff training data when this is requested.
- The trust should ensure that staff clearly explain to patients what their rights are under the Mental Health Act, where this is relevant.
- The trust should ensure that staff support patients when they are referred or transferred between services.
- The trust should ensure that staff know about carers assessments and how to offer these.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

- Leaders did not always understand and manage the priorities and issues services in Forward Thinking Birmingham faced; significant improvement was still required in the quality of healthcare relating to management of risk due to issues with records.
- We were not assured there were effective structures, processes and systems of accountability in Forward Thinking Birmingham.
- Leaders had not always identified and escalated relevant risks and issues and identified actions to reduce their impact.

However:

- Most leaders had the skills and abilities to run the service, where support was required, this was provided. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Our findings

- Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust promoted equality and diversity and inclusion (EDI) in daily work and provided opportunities for career development.
- The trust had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated mostly effective governance processes, throughout the trust and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leadership

Most leaders had the skills and abilities to run the service, where support was required, this was provided. However, they did not always understand and manage the priorities and issues services in Forward Thinking Birmingham faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust board was a unitary board and included six voting executive directors, one of whom was the trust chief executive, and seven non-executive directors (NEDs), one of whom was the trust chair.

Most leaders had the skills, knowledge and experience that they needed; both when they were appointed and on an ongoing basis. Where support was required, this was provided. The chief executive recognised the strengths and areas for development or support in the senior team and provided these to ensure the team were effective in discharging the board remit.

Leaders did not always understand and manage the priorities and issues services in Forward Thinking Birmingham faced. During our core service inspection in July 2022, we found concerns within the specialist community mental health services and on the child and adolescent mental health wards. We revisited the services between 10 and 11 October 2022 and found that significant improvement was still required in the quality of healthcare relating to management of risk due to issues with records.

At the time of this inspection the interim chief financial officer (CFO) was formerly the deputy director and had been in post since April 2021. Interviewing for a substantive CFO was due to take place in September 2022.

The chief nursing officer (CNO) had worked at the trust for over 22 years, in this role for three years and was retiring at end of August 2022. The current and incoming CNO had a four-week handover period, with the incoming CNO having been in post for two weeks at the time of this inspection.

The Director of Mental Health Services had worked at the trust for over nine years and was previous the chief operating officer (COO) prior to this role. The Director of Mental Health Services had responsibility for the mental health services, Forward Thinking Birmingham.

Our findings

The chief officer for strategy and innovation (COSI) ran a well-resourced team managing a range of projects. Particular exemplary aspects of the functions that reported to the COSI was an internal consultancy capability led by a public health consultant, using senior registrars and with support from band six analysts. The COSI was able to describe, with energy and enthusiasm, quality improvement projects that existed, not only at a local 'front line' level but trust level transformation work. For example, where the trust was on the various big digital projects that were work in progress.

The trust had a range of suitably skilled and experienced non-executive directors. The chairs of both the audit and finance and resources committees were qualified accountants with senior leadership experience in the NHS and each also held non-executive appointments within West Midlands integrated care boards.

The trust had a council of governors made up of elected and appointed people who were volunteers. The council of governors were responsible for ensuring the trust was publicly accountable for the services it provided. Governors' views were shared with the board of directors through formal meetings chaired by the trust chair and attended by the non-executive directors. The executive directors were invited to attend the meetings to present reports and information.

The views of members and the public were captured by the governors through engagement with patients, either directly through walkabouts (outside the pandemic period) or indirectly through receipt of patient experience information.

The governors' scrutiny committee provided a forum to support the council to meet its obligations, in particular to hold the non-executive directors to account. This committee was chaired by the deputy chair and had a core membership of governors. Meetings of the committee were also attended by non-executive directors and executive directors for appropriate agenda items.

During this inspection we met with three of the governors, two of which, were relatively new to the trust and described a supportive network was in place. The governors were clear of their role and responsibilities and had all received an induction programme. They all spoke of an inclusive culture in the trust and felt very welcomed and valued.

An external review of leadership and governance at the trust was last carried out in February 2019. Recommendations identified as a result of this review had been worked through by the board with significant developments in some areas. For example, previously, information from the people committee had been submitted to both the finance and resources committee and quality committee. Information was duplicated and there was a risk of blurred accountabilities. Work had been undertaken to decide what information should be presented at each committee and had been implemented into the committees' agendas.

The trust had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership and had invested significantly in a number of leadership programmes, many of which had been paused during the early part of the COVID-19 pandemic.

As a result of the COVID-19 pandemic, leaders had not been as visible across the trust. The board agreed at the start of the pandemic that while transmission of COVID-19 was still a risk within the trust's hospitals, non-executive directors would not routinely attend trust sites. However, the board maintained virtual contact with staff throughout by attending virtual staff engagement events and staff meetings and participating in staff engagement initiatives, including for example, ByYourSide mentoring initiative, staff network meetings (representing staff with protected characteristics), staff listening and engagement events and social media.

The chief pharmacist regularly visited all areas and departments across both the women's and children's sites within the trust by 'walking the floor' this ensured that they were visible and approachable to all staff across the trust.

Our findings

The pharmacy senior leadership team worked well together and supported the chief pharmacist. There was a positive culture of challenge and discussion between each other. The chief pharmacist was also supported through good relationships with the medical director and the clinical director. Pharmacy staff said they felt supported and very comfortable approaching the chief pharmacist about anything and knew they would be listened to.

The main challenge to the quality and sustainability of the pharmacy service was staffing. There was a 27% vacancy rate with a high turnover of staff within the dispensary and stores areas. Much of this was due to staff progression as well as leaving the trust although many did return. Although this had caused instability and stress for staff, they commented that despite this they were 'coping' to ensure that medicine safety was maintained to a high standard as a priority to patients.

The pharmacy team were very proud that they had received an award for the most outstanding clinical team of the year last year.

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of three executive directors and two non-executive directors to determine the necessary fit and proper person checks had been undertaken. We found all files were fully compliant with FPPR.

Vision and Strategy

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

Following the merger of the women's and children's hospitals in 2017, the trust undertook a wide consultation with staff and other stakeholders on their vision, mission, goals and values as a single organisation. These had been embedded in the trust since that time and had guided the trust's strategic direction.

The trust's goal was to be 'The best place to work and be cared for, where research and innovation thrives, creating a global impact'. The trust vision to be, 'a world-leading team providing world-leading care' was underpinned by three key values: Ambitious; Brave and Compassionate.

At the beginning of 2022/23 the trust began a process of reviewing the strategic priorities aligned to the goals, building on learning from the pandemic and reflecting increased system working. The trust had engaged with staff throughout the summer on the development of work programmes aligned to seven agreed objectives. Staff knew and understood what the vision, values and strategy were, and their role in achieving them and were committed to the values of the organisation and had requested that these were not changed.

The trust objectives were aligned to local plans within the wider health economy including, but not limited to, developing a structured approach to working with operational delivery networks and the national children's hospital alliance, which would maximise the opportunities to transform clinical care across regional and national paediatric services. A key element was to ways of working with the new integrated care board.

Our findings

Performance against the objectives were monitored through the board subcommittees through the operational performance report and finance report. Threats to delivery of the strategy were reported through the board assurance framework.

In mental health, the trust had a Birmingham and Solihull Mental Health Provider Collaborative strategy, which set out a proposed approach to how the trust planned to work with other providers in the local area for change in the system and for the commissioners to identify the outcomes they wish to see.

In 2020/21 the trust launched a staff inclusion and diversity (EDI) strategy, linked to the trust's strategic objective to create 'the best place to work' and aligned to the trust's Workforce Race Equality Scheme and Workforce Disability Equality Scheme submissions. The development of the EDI strategy and resulting priorities had been an important piece of work, enabling the trust to make significant progress in a number of areas.

The trust had elected to adopt a two phased approach to developing the strategy, initially prioritising the development of the staff strategy. This was in response to key themes identified following the staff survey and workforce race equality standards (WRES).

The inclusion and diversity committee had been important in overseeing the work to date and had helped to shape the staff EDI strategy. This included extensive engagement with a range of stakeholders and partners, including:

- The staff networks umbrella group.
- Individual staff network groups.
- Trade union partners.
- Integrated care system.

The trust was currently progressing the second stage of the EDI strategy, which was specifically focusing on EDI for patients and families. The draft document was developed in partnership with the patient experience team who had engaged with healthwatch, as well as with the trust's young person's advisory group, Think4Brum advisory group and maternity advisory group.

The inclusion and diversity committee, chaired by the chief executive, provided board level oversight of strategy implementation, with support and challenge from advisory members that included the trust's staff ambassador, inclusion ambassador and chair of the staff inclusion, diversity and equality action group (IDEA).

Areas of focus during 2022/23 included the trust's gender pay gap, responding to the results of the staff survey, a new appraisal process and flexible working policy, and the continued development of staff networks.

There was a clear vision and strategy for the delivery and improvement of cancer services, in partnership with other providers, such as the West Midlands Cancer Alliance and the Birmingham and Solihull Cancer Programme Board. The trust's involvement in a single strategic system-owned plan was to lay the foundation for a system transformation over the next five years to ensure, as a region, the focus was on delivering: improved quality of life outcomes; improved patient experience outcomes; reduced variation; and reduced inequalities.

The pharmacy department had a business transformation plan for 2021-22 which was currently being reviewed by pharmacy staff for their priorities and vision for 2022-23. Education and training were going to be the main feature for the following year with a focus on medicine safety trust wide.

Our findings

Pharmacy staff were sighted on the trust values which formed part of their performance development review (PDR) process. This was also used as a basis of the pharmacy teams 'Star of the Month' where individuals and teams were nominated by the department and received a certificate and a pen.

Culture

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

Most staff felt supported, respected and valued. Feedback from our staff focus groups was largely positive with staff speaking highly of the executive leadership team. However, some staff working within Forward Thinking Birmingham (FTB) believed there to be a 'disconnect' between FTB and the wider trust; staff reported good communication with immediate line managers but felt there was a 'block' at middle management level and a disconnect with those higher up [executive level]. Challenges experienced in their day-to-day work such as a perceived lack of investment in FTB staff to support their development and poor IT access, equipment and existing programmes did little to make this group of staff feel valued.

The trust had 1.8 whole time equivalent Freedom to Speak Up Guardians known as 'Staff Ambassador' and 'Inclusion Ambassador'. Trained through the National Guardian's Office (NGO), both ambassadors supported staff to speak up when they felt that they are unable to in other ways.

The Freedom To Speak Up (FTSU) index is a metric for NHS trusts, drawn from four questions in the NHS annual staff survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident. The FTSU index score for this trust was 80.9% and above the national average of 79%.

Equality and diversity were promoted within and beyond the trust. Staff we spoke with, including those with particular protected characteristics under the Equality Act, felt they were treated equitably. The trust had implemented many EDI related initiatives for staff. In 2021/22 the trust launched or refreshed a number of initiatives and tools under the 'Safer Together' banner. Initiatives included for example, the 'Stop. Challenge. Change' tool providing staff with a confidential way to report any incidents of discrimination, harassment or bullying that they experience or witness. The tool was also used to share experiences or raise general concerns and observations. In addition, the trust had established and developed the role of the inclusion ambassador across the trust to support staff to raise concerns ensuring their voice was heard.

Improvement for staff during 2021/22, included the proportion of staff reflecting the diversity of the trust's communities, and the staff survey results which showed that more staff from a BAME background believed the trust offered equal opportunities to career progression and promotion.

Mechanisms were in place for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations. However, not all staff had received this opportunity. We saw low staff appraisal rates in the division of corporate services (63%) and the division of mental health services (62%).

The board were fully sighted on the level of performance in these two services and were actively reviewing and scrutinising performance through the trust board and respective sub-committees. Specifically:

Our findings

- Appraisal rates were embedded within the performance dashboard metrics and were reviewed every month through both the quality committee and finance and performance committee. This included detailed scrutiny and challenge from non-executive directors (NEDs) as well as between executives.
- Workforce metrics were reviewed within all divisional quarterly performance review meetings and as part of divisional team meetings.
- The chief people officer had escalated issues with appraisal performance to both corporate and executive directors and within specific clinical services.
- The trust had launched a new simplified appraisal process during July 2022 due to feedback from staff regarding the previous process and documentation.

Following our inspection, the trust told us, some appraisals had been delayed whilst work was finalised on the trust objectives in order that, the new priorities could underpin the objectives of the chief officers and in turn the managers and teams that reported to them. All chief officer appraisals were now complete. Where delays remained, the appraisal policy enabled regular check-in meetings between line managers and individuals to provide a more regular oversight of performance and well-being.

Since the well led inspection, the trust had put in place the following additional key actions:

- The chief people officer was overseeing a recovery programme and had written directly to all service leaders with outstanding appraisals requesting a detailed improvement plan and timeline.
- Each line manager was now required to provide a detailed improvement trajectory showing week on week rates, which were to be monitored by the chief people officer, with additional scrutiny from both the quality and finance and resources committee.

During the past year, supporting staff with COVID-19 had continued with wellbeing checks for staff who were unwell, self-isolating or shielding. Individual COVID-19 risk assessments for all staff had continued, along with regularly refreshed assessment and guidance. The trust had also continued to support staff members affected by long-COVID-19.

Sickness absence was monitored and reported each month through the governance framework. Recent board reports commented that sickness absence was above the target. Particular challenges were addressed through bespoke support and through management and human resources interventions.

The trust's occupational health service, provided externally, included pre-employment screening, health validation, health screening and advice and guidance on employee health and absence, as well as a 24-hour helpline. During 2021/22 a COVID-19 referral route was also made available for managers requiring specialist advice on COVID-19 risk or illness.

The trust's attendance management policy had been reviewed to ensure a just culture was reflected in the process and that consideration was given to wellbeing indicators triggering managerial sickness review processes. Implementation of the policy included training for managers along with a revised supporting absence management toolkit.

The NHS Staff Survey took place in Autumn 2021 which was 18 months into the pandemic. National results reflected the context of a prolonged and demanding period and its impact on peoples' personal and working lives. The response rate for the staff survey was 43% (2451 staff responded), this was a slight decrease from the previous year (3% lower).

Our findings

For 2021, the NHS Staff Survey was redeveloped to align it with the NHS People Promise, first published in July 2020 as part of the NHS People Plan 2020/21. The move to link questions to the NHS People Promise themes meant comparison with 2020 data was limited. Seven of the overall themes were new and therefore could not be compared with previous years.

In 2021 the NHS nationally had seen declining scores in many staff survey domains, including the two areas which could be compared to the 2020 results: staff engagement and morale. This decline was also reflected in the trust's scores.

While there were positive improvements in this year's survey, specifically around the areas of career progression for BAME colleagues, flexible working and completion of appraisals, there were several areas requiring focus for improvement in 2022/2023. These included, burnout, thinking about leaving, work pressures and health and safety climate. The staff survey results for 2021 were included in the trust's board assurance framework and we saw where these had been discussed at a trust board meeting in July 2022. In addition, a programme of staff engagement commenced in June 2022.

The culture encouraged openness and honesty at all levels within the organisation, including with people who used services, in response to incidents. The number of severe/moderate harm incidents and related deaths that had followed duty of candour was 170.

The culture centred on the needs and experience of people who use services. Overall, the trust appeared to have a robust and comprehensive process in place. The complaints and Patient Advice and Liaison Service (PALS) team were separate but worked closely together. Both had links with supporting services for example, the learning disability team.

A regular complaints meeting was held chaired by the chief medical officer, where complaints were discussed and decisions around whether or not they should be escalated serious incidents was made. The complaints team attended the heads of nursing meetings, these were not minuted however, the divisional quality meetings were at which the clinical leads were charged with following up complaints and assuring that actions were met.

During our inspection of well led we reviewed five complaint responses. All responses were clear and transparent throughout. The two-stage process involved a synopsis and letter from the investigating manager and once the required time period had lapsed without further patient input/follow up a further follow up letter with any relevant updates was sent from the chief executive. We noted that responses to complaints were very empathetic and compassionate.

Medicine safety was highly dependent on people reporting medicine incidents and raising issues with a strong no blame culture. There was a good incident reporting culture. The chief pharmacist liaised with the medicine safety officer, governance lead and patient safety nurse. Actions and learning from any reported medicine errors were shared across the trust and a report was sent to the medicine safety committee and to the clinical safety and quality committee. This included an internal near miss report as part of the pharmacy report.

A recent Care Quality Commission inspection highlighted concerns with recording times of administration of medicines especially for time critical medicines. Immediate action was taken by the pharmacy team which addressed the issue and discussed with nursing staff. The medicine policy was currently being updated to ensure clarity and understanding of time critical medicines.

Our findings

Governance

Leaders operated mostly effective governance processes, throughout the trust and with partner organisations. However, we were not assured there were effective structures, processes and systems of accountability in Forward Thinking Birmingham. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were mostly effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. The trust had implemented a coherent and robust governance structure to ensure there was effective monitoring and assurance processes in place. The trust's board of directors maintained effective oversight of performance through monthly board meetings. To aid transparency, trust board meetings were mostly held publicly, only those matters of a commercial or personal confidential nature were considered privately. Board and committee papers, we reviewed demonstrated there was bold decision making of the board that underpinned the strategic direction of the trust.

Staff were clear about their roles and understood what they were accountable for, and to whom Much of the scrutiny of performance and quality of care was undertaken through meetings of the board's sub-committees, the finance and resources and quality committees. This scrutiny was complemented by an active focus on governance, financial management and value for money by the audit and value committee.

From our observations of both the board and sub-committee meetings and interviews we were assured there was a clear governance structure for monitoring progress and assurance. However, we were not assured there were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services in Forward Thinking Birmingham (FTB). FTB as well as being a provider, was contracted by the commissioners to manage a sub-contractual arrangement for inpatient beds. This service provided beds for patients up to 25 years who needed a mental health bed. This was in addition to the trust's own beds for child and adolescent mental health services (CAMHS) patients at Parkview. The trust held monthly contract review meetings with the independent provider. However, trust managers directly involved in these sub-contractual arrangements were not able to demonstrate that they understood the governance structures or had sufficient oversight of the quality of the sub-contracted arrangements."

To address the volume and complexity of the risks we identified during the core service inspections of mental health services, the trust had:

- Seconded a senior member of the quality governance team into the mental health division to support the development of its governance and reporting model.
- Established a weekly divisional governance meeting, chaired by the chief medical officer or chief nursing officer, in recognition that a greater level of executive oversight was required.

The trust had commissioned an external independent review of their mental health quality governance model from an experienced former mental health trust chief executive officer. The trust were acting on the findings of this review at the time of our inspection.

We also found a lack of governance and oversight relating to patients "lost to follow up" and the management and investigation of incidents for the Forward Thinking Birmingham teams. Furthermore, when FTB's electronic system, Carenotes, used for recording patient information including care records became unavailable due a national cyber-attack, there was no clear business continuity plan in place, meaning a delay in introducing new systems and ways of working. We were provided evidence to show the system became unavailable on 4 August 2022 but that the interim

solution in place at the time of our visit was not initiated until 1 September 2022. We were also provided with evidence that showed as of 14 October 2022 there was no clear recovery plan in place for when the original recording system becomes available again. This meant there was no clear plan for ensuring patient risk assessment and management documents were appropriately migrated, up to date, and available to staff when the original system becomes available again.

Several actions were immediately put in place by the trust following our initial feedback and urgent letter of intent from the mental health core service inspections. The key elements included:

- All outstanding clinical incidents had been reviewed, investigated and closed.
- Robust real time performance tracking of risk assessments and clinical incidents had been embedded across the division, including the use of daily team huddles / ward round reviews.

The trust had implemented many equality, diversity and inclusion (EDI) related initiatives for staff. There was a newly created post, head of EDI with a team. The infrastructure and governance structures were in place. The trust reported on the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Both showed there were pockets of good work and areas for improvement in some of the indicators.

There was a strong governance structure in place for the safe use of medicines with a clear line of reporting through the organisation to the clinical safety and quality committee and direct to board level. There were no gaps in reporting lines between the committees with a visible pharmacy presence. The chief pharmacist was professionally accountable to the medical director and met up on a monthly basis.

Outsourcing with partners such as all the home care suppliers and major suppliers were well managed with regular contract meetings. Regular meetings were also undertaken with the 'The Medicine Chest' which was the main outpatient dispensary at both locations.

The trust did not have an aseptic service so relied heavily on outsourcing and obtaining aseptic preparations direct from manufacturers or from a nearby NHS trust. This had been well managed primarily because it was a children's service. Outsourcing was increasing so an Integrated Care System (ICS) project was also being looked at on how everyone could work together to ensure it was undertaken safely and correctly.

In order to close the gaps in assurance and develop medication safety initiatives the team wanted to expand the trust safety team and include a dedicated safety pharmacist which would form part of the multidisciplinary patient safety programme design.

Financial governance

In the financial year 2021-22 the trust had achieved a surplus of £5.5m, £5.2m ahead of the agreed plan, and received an unmodified opinion on its accounts from the trust's external auditor. Internal auditors had given the trust board their opinion that there was significant assurance that internal controls operated as intended.

For 2022-23, the trust had submitted plans through the Birmingham and Solihull integrated care system to deliver a break-even financial position, based on an estimated trust annual turnover of £535m. The trust told us that it had started the year well, in financial terms, by reporting an underspend on its agency staff costs; however, it recognised that achieving its cost improvement target of £12m recurrently remained challenging and was an area of risk.

Our findings

The trust had a track record of exceeding its planned financial targets and its financial resilience was evidenced by its high level of cash balances, starting the year with £146m. It had set a capital programme of £32m for the 2022-23 financial year and at this early stage of the year was reporting that it was on track to spend to this plan.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, they had not always identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk assessment policy set out the responsibilities and accountability for the assessment of risk and provided guidance on day-to-day risk management.

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. The trust's risk management framework supported the organisation to understand the risks it faced and to make informed decisions about the extent to which risks could be tolerated and controlled. This was achieved through governance systems and frameworks, risk management tools and staff training. However, we were not assured arrangements were robust. Not all relevant risks had been considered. Risks identified during our core service inspections in surgery and Forward Thinking Birmingham (FTB) had not been identified for example, there had been delays to the actions undertaken to mitigate risks with some serious incidents dated back to 2020 in FTB. Following our core service inspections, the trust had been quick to respond to our serious concerns and actions were taken. However, when we re-visited the community mental health services in October, we found that measures put in place were not effective in mitigating risk to patients. Staff were unable to effectively use electronic record systems to retrieve or store important patient information relating to patient safety and risk, despite additional training and oversight in place, and were not using team huddles effectively to share pertinent patient information.

Prior to our inspection the trust had identified a significant number of patients (over 1,000) categorised as "lost to follow up" within the community mental health teams. This meant that staff had lost contact with the patient, that they did not have a next appointment and had not been allocated a care coordinator. During our inspection of the core services, managers were unable to accurately identify exactly how many patients were lost to follow up. Whilst the trust was taking action to make contact with all of the patients it had identified, we saw that some patients who were lost to follow up had come to significant harm. The trust's governance processes to prevent patients becoming lost to follow up had been ineffective.

To address the volume and complexity of risks identified in FTB, a senior member of the quality governance team had been seconded into the mental health division to support the development of its governance and reporting model. This individual was just embedding at the time of the well led inspection. A weekly governance meeting had also been established, chaired by the chief medical office or chief nursing officer in recognition that a greater level of executive oversight was now required.

The board and committees focused on the management of strategic risks through, what the inspection team considered to be, generally a well-developed board assurance framework (BAF) with updates provided at every board meeting. The BAF described the ways in which each risk was controlled, the assurances as to the effectiveness of those controls, and the additional mitigating actions required. The board agreed its appetite or tolerance for each individual risk by setting a target risk score, which was regularly reviewed and updated. However, we found risks associated with mental health services did not always have clear actions in place to mitigate the identified risks and/or proposed completion dates.

Our findings

The board of directors had ultimate responsibility for risk management and internal control. The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. This responsibility was managed through the board's corporate governance arrangements, including layers of risk reporting through the board's committee structure, which ensured a link between risk management at board and at local department level.

Ward to board management of risk appeared to work effectively with the trust board sighted on significant risks across most of the divisions, with the exception of mental health. We were told of an example of a 'risk summit' held in the women's division as a result of a number of contributing factors suggesting there was an increasing level of risk within this division. Despite not recognising all risks within the mental health division (Forward-Thinking Birmingham), the trust told us there were plans to replicate this 'risk summit' within the mental health division.

There was a programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The internal audit plan 2022/23 was submitted for approval to the audit and value committee in May 2022 and focused on areas such as workforce planning, recruitment, health inequalities, waiting lists and elective recovery, which were emerging themes across the divisions. Given the high number of red risks related to staffing, workforce planning was to be considered a priority, focusing on high turnover and retention.

Business cases were reviewed by the finance and resources committee and by the board if appropriate. Prior to the inspection the board had approved investment in an electronic patient record system (EPR).

The trust's estates capital expenditure was project managed through its wholly owned subsidiary Vital Services Ltd; and was working in partnership with neighbouring trusts to gain efficiencies of scale through shared procurement arrangements.

The pharmacy department had an active risk register with action plans in place to record and manage the identified risks. There was one high risk area on the register. The pharmacy team did not currently have the right leadership or right skill set in place for haematology and oncology services. The service was currently out for recruitment for a band 8B pharmacist. There were also two ongoing identified risks for the safe medicine optimisation service, safe and secure storage of medicines and staffing. However, despite the challenges one risk area had now been acted upon with the opening of a brand-new medicine room on the delivery suite at the Women's Hospital.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities with business continuity plans and arrangements in place. We saw the trust coped well with unexpected events and were managing a significant issue at the time of the well led inspection.

Information Management

The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, in FTB services, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Our findings

Key performance indicators covering finance, operations, quality and people were regularly monitored within the trust by the relevant operational and corporate teams and reported regularly to the board of directors via detailed reports to the board committees and a quarterly integrated performance report to the Board.

Performance indicators included those that were mandated and monitored at a regional and national level as well as those set locally. The latter linked to best practice, quality improvements, areas of risk and objectives. Performance against these indicators was used to inform the content of the board assurance framework (BAF) as a source of assurance on the effectiveness of controls.

Information technology was key to the trust in realising its ambition to be a digitally mature organisation with this identified as one of the priority themes approved at board. Four deliverables had been identified to realise this ambition; to develop a fully resourced digital roadmap setting out the trust approach for achieving a minimum of Healthcare Information and Management Systems Society (HIMS) level 5 by the end of 2023; to develop the business case and receive approval for a new trust electronic patient record (EPR); to demonstrate an integrated quality improvement (QI)/digital approach to transform key operational processes, starting with outpatients and booking and to demonstrate an integrated QI/digital approach achieving true transformational change in a clinical service.

The business case for the investment and implementation of an Electronic Patient Record (EPR) and Electronic Prescribing and Medication Administration (EPMA) system had been approved by the board in August 2022. This would provide digital support as well as analytics for prescribing and medicine administration. Some parts of the trust had an EPR in place such as maternity and mental health services and plans had been in place to develop an EPR already in use with a partner organisation however this had not proved to be suitable for the services provide by this trust.

There were internal processes for monitoring the pharmacy service such as key performance indicators (KPI) for the time taken to dispense medicines despite the staffing challenges. The chief pharmacist provided assurance of the KPI's in a quarterly report at the clinical safety and quality committee.

Arrangements were in place to ensure that data or notifications were submitted to external bodies as required. This included, but not limited to, the Care Quality Commission, commissioners and the local authority.

There were robust arrangements (including appropriate internal and external validation) in place to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. During 2021/22 four serious incidents requiring investigation (SIRI) related to information governance were reported within the trust. Each incident was reported to the Information Commissioners Office (ICO) whereby no action was taken.

The Data Security and Protection Toolkit assessment had been completed and independently audited in May 2022. This audit assessed the overall design and operation of key mandatory data security and protection toolkit controls at the trust and provided 'significant assurance with minor improvement opportunities'. The final submission submitted to NHS Digital in June 2022 showed that the trust had not met all standards.

The trust had introduced a patient portal called 'Doctor Doctor' for patients to access online appointments, however this did not comply with the Accessible Information Standard and information was not made available in alternative formats and or languages.

Our findings

In FTB services, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The electronic records system in FTB did not always state the outcome of the appointment resulting in the risk of patients becoming lost to follow up.

Engagement

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

The trust was the lead provider of the West Midlands CYPMHS Provider Collaborative (WMCPC); an integrated provision of specialist mental health, learning disability and autism services, for young people aged 12-18.

Provider collaboratives were established across England to encourage closer regional partnership working. This meant, pathway and budget management were WMCPC's responsibility, giving the collaborative the autonomy and opportunity to reinvest savings into community and step-down services that the region's young people needed the most.

During 2021/22 the trust continued to use virtual and in-person methods of consulting with and engaging patients, service users, families and communities to involve them in the continuous improvement and development of services. The trust had two youth advisory groups, supporting Birmingham Children's Hospital and Forward-Thinking Birmingham. Both groups met together on a quarterly basis and collaborated on trust-wide projects, acting together to bring about change for the young people using services. During our observation of a trust board meeting in August 2022 we saw representation from both groups actively participating in this meeting.

The Young Persons' Advisory group (YPAG) was a youth engagement group at Birmingham Children's Hospital. The group was involved in everything from interviewing staff to advising on consultations. Think4Brum was an engagement group for Forward Thinking Birmingham (FTB), the trust's 0-25s mental health service. T4B gave young people an opportunity to get directly involved in FTB, helping the trust to shape the design and delivery of services.

The Friends and Family Test (FFT) gives all patients or their families the opportunity to leave feedback on their care and treatment. The FFT includes the question, *Overall, how was your experience of our service?*

The trust launched a new patient survey portal in April 2021 and its promotion had led to an increase in FFT response rates throughout the year. in 2021/22, 4,513 responses were received with 87% positive responses. The new patient survey portal enabled the trust to collect accurate demographic data and compare these reliably against satisfaction for the first time. The trust was to use this data to make positive improvements in the experience of patients and families, and a new patients and families ambassador for inclusion and diversity was to be instrumental to this work.

The trust collected information on patients' race and ethnicity in order to measure disparities in care to see if they existed in the organisation and to initiate programs to improve quality of care. Analysis of ethnicity data for 2021/22 demonstrated, satisfaction levels in FFT were lower than the trust average of 87% in all ethnic categories, people from a black, Asian and minority ethnic (BAME) background were more likely not to attend an outpatient appointment in children's, women's and mental health services.

The trust's plans to identify and address inequality of access, experience and outcomes in healthcare were underpinned by a range of initiatives focused on engaging with patients, families and communities.

Our findings

The trust worked with partner organisations to enhance knowledge and understanding and to seek engagement with wider communities. For example, Maternity Voices Partnership, Healthwatch, Contact (for disabled children and their families) and communities (through Birmingham Voluntary Services Council).

The chief pharmacist attended the West Midlands Chief Pharmacist's network to ensure consistency to share and learn medicine optimisation issues across the Midlands region. Local engagement with the area prescribing committee also ensured that health economy wide issues were discussed to help improve patient care.

Pharmacists attended multidisciplinary team meetings at ward level for specialist area such as cystic fibrosis, renal, critical care and dermatology and in as many other areas as possible. The pharmacy team also had internal team briefs or huddles every morning with a check in at lunchtime. The chief pharmacist had a department virtual call twice a week for a general catch up with staff.

The presence of a medicine's management nurse based within pharmacy was a valuable link between pharmacy and nursing staff.

Pharmacy staff had a diverse range of different languages such as Afghan, Urdu, Punjabi, Malaysian and Chinese speaking which helped with the counselling of patients and their families. A quality initiative on one ward used interpreting services which included pharmacy staff for teaching families on medicines. The team also described the use of colour coding initiatives, stickers and pictures of medicines and working alongside nursing staff to provide extra instruction to parents and families.

Staff in the safeguarding team worked with the local Integrated Care Board health lead for Special Educational Needs and Disability (SEND).

The trust was committed to involving, consulting and engaging with staff. Throughout our interviews we heard the phrase, 'creating the best place to work.' The trust involved staff in decisions about the future strategy, their working environment and the development of services through a variety of methods including:

- An annual staff engagement week which was used to inform the development and implementation of the trust's strategic objectives.
- Listening events.
- An active programme of engagement operated by the Staff Ambassador (Freedom to Speak up Guardian) and Inclusion Ambassador.
- Quality Improvement methodology and processes.
- Joint Consultative and Negotiation Committees (JCNC).
- A regular email bulletin containing trust news.
- Regular chief executive briefing sessions.
- Invitation to board of directors' meetings in public.
- Staff networks.
- Inclusion, Diversity and Equality Action (IDEA) Group.

Our findings

Feedback on staff engagement was monitored during the year by local surveys and annually by the National Staff Survey. The results from these surveys informed the trust's plans and areas of focus.

Learning, continuous improvement and innovation

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

Leaders and staff strove for continuous learning, improvement and innovation. This included participating in appropriate research projects and recognised accreditation schemes. Throughout our inspection process we heard numerous examples of staff at all levels using quality improvement methods to make changes to their ways of working.

The trust had been developing quality improvement (QI) programmes over the last three to four years, upskilling staff and encouraging quality improvement champions. Active QI huddles took place across the trust, with 'huddle boards in most areas, these took the form of 'trees of improvement' bearing acorns which detailed the project name, a summary and the key contact person.

Despite the challenges of the COVID-19 pandemic and the impact for patients, with long waiting times, a surge in referrals, and significant increases in need, staff had worked innovatively and with enthusiasm to ensure they cared for their women, children and families to the highest standards possible. Achievements over the last year included for example, midwives were recognised for their Avoiding Term Admissions into Neonatal Units (ATAIN) project, a donation of just over £1million enabled the purchase of a next generation sequencing platform to support the rapid expansion of cancer genetic testing at the West Midlands regional genetics laboratory, neurosurgeons successfully performed the first ever Pial Synangiosis to treat children with a rare disease called Moyamoya, teams worked hard to drive down long waiting times, achieved through increased theatre access, extended hours and smarter ways of working and the mental health service took part in ground-breaking research to improve patient outcomes in early psychosis.

The trust participated in a number of accreditation schemes including for example, United Kingdom Accreditation Service (UKAS) schemes for both pathology laboratories and genetics. Recent accreditations included International Standard ISO 15189:2012 - Medical laboratories - Requirements for quality and competence. In addition, the trust was also working towards the Imaging Services Accreditation Scheme (ISAS) and Anaesthesia Clinical Services Accreditation (ACSA).

As part of this inspection, we looked at the trust's processes for reviewing deaths. The trust used the structured judgement review (SJR) methodology. We reviewed five cases where a SJR had been carried out. We saw the care received by patients who had died had been effectively reviewed, areas of learning had been identified and the reviews supported the development of quality improvement initiatives when problems in care were identified.

Systems were in place to support and encourage pharmacy staff in improvement and innovation. Pharmacy staff said that although there were opportunities available and they were supported to learn and develop they did not always have the time to do it due to the staffing issues which causes some frustration.

Learning from people's views and experiences was important to the pharmacy team. One example was given where issues had been reported of long queues developing outside the Medicine Chest, outpatient dispensary, at the children's

hospital. Waiting times were poor, accuracy of dispensing was not always good, and the attitude of staff had been commented upon. It was primarily due to the service being run by 90% locums. This was addressed with a change of leadership and lots of support. The service now had a substantive pharmacist and many of the locums were staying permanently.

Innovation was a key priority for the pharmacy team and despite the time restraints they actively looked at different projects. One example was initiative undertaken together with cardiology to improve engagement with patients and families. Pharmacy supported the development of a competency package for parents and families on how to safely administer complicated regimes of cardiology medicines.

The safeguarding lead told us about how the learning from the death of a child in Solihull had been disseminated to staff across the trust. They used virtual and face to face bitesize sessions to make it meaningful to staff and how it affected their day-to-day work.

Following the death of a young child of a patient that used the services of Forward-Thinking Birmingham the safeguarding team had tailored specific scenario training for staff. They were providing staff with this training at the time of our inspection and reported that staff had identified further learning identified as part of this. They were to feed this back to the senior leadership team so this further training could be provided.

The trust had received funding for staff training in working with people with a learning disability and were aligning this to the 'Oliver McGowan training'. (This training is mandatory for health and social care staff following the death of Oliver at 18 years old). They had received funding for a post at Birmingham Women's Hospital to work with people with a learning disability and were designing a training package for staff. They had also submitted a funding bid to design a room in the Emergency Department at Birmingham Children's hospital, so it was more accessible to children with a learning disability and autistic children.

A five-year research and development (R&D) strategy was approved by trust board in February 2018. It prioritised a desire to build a strong research culture and make research part of 'core business'. The strategy set out three key objectives of participation, academic partnerships and research delivery/ impact. In 2022 an evaluation of stakeholders views and experiences was undertaken to assess the changes which have occurred since the launch of the strategy in 2018 and to establish whether research had become part of 'core business'. Stakeholders were reported to have been keen to speak about the achievements in R&D over the last four years, whilst acknowledging the impact of the COVID-19 pandemic. The Clinical Trial Scholars (CTS) programme was considered the greatest achievement. The second was improved R&D governance structures with a clear line of reporting, performance review meetings and research featuring in the trust values.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Mar 2023	Good ➔➔ Mar 2023	Good ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Outstanding	Outstanding	Outstanding	Good	Outstanding
Mental health	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate	Inadequate
Overall trust	Requires Improvement ➔➔ Mar 2023	Good ➔➔ Mar 2023	Good ➔ Mar 2023	Requires Improvement ➔ Mar 2023	Requires Improvement ➔ Mar 2023	Requires Improvement ➔ Mar 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Birmingham Children's Hospital	Good ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023	Good ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023
Birmingham Women's Hospital	Requires improvement Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Overall trust	Requires Improvement ➔➔ Mar 2023	Good ➔➔ Mar 2023	Good ➔ Mar 2023	Requires Improvement ➔ Mar 2023	Requires Improvement ➔ Mar 2023	Requires Improvement ➔ Mar 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Birmingham Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Outstanding ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023	Good ➔ Mar 2023	Good ➔ Mar 2023	Outstanding ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017
Medical care	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Neonatal services	Inadequate Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Requires improvement Feb 2017	Requires improvement Feb 2017	Requires improvement Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	Not rated	Outstanding Feb 2017	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017
Surgery	Requires Improvement ➔ Mar 2023	Good ➔➔ Mar 2023	Good ➔ Mar 2023	Good ➔➔ Mar 2023	Good ➔➔ Mar 2023	Good ➔➔ Mar 2023
Transition services	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Urgent and emergency services	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Overall	Good ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023	Good ➔➔ Mar 2023	Outstanding ➔➔ Mar 2023

Rating for Birmingham Women's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement Nov 2019	Not rated	Requires improvement Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Requires improvement Nov 2019
Gynaecology	Requires improvement Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Maternity (community services)	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Neonatal services	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Maternity	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Overall	Requires improvement Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Inadequate ↓ Mar 2023	Requires Improvement → ← Mar 2023	Requires Improvement ↓ Mar 2023	Inadequate ↓ Mar 2023	Inadequate ↓ Mar 2023	Inadequate ↓ Mar 2023
Child and adolescent mental health wards	Requires Improvement ↓ Mar 2023	Good → ← Mar 2023	Good → ← Mar 2023	Good → ← Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023
Mental health crisis services and health-based places of safety	Requires Improvement ↓ Mar 2023	Good ↑ Mar 2023	Requires Improvement ↓ Mar 2023	Good → ← Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023
Overall	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate	Inadequate

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Mental health crisis services and health-based places of safety

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff within the mental health crisis service were based at Parkview clinic, but patients did not access this building as staff met with patients in their homes or in other community buildings, such as schools. The CAMHS crisis team also operated a health-based place of safety for children and young people up to the age of 18, however we did not inspect this as it was closed at the time of our inspection.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The crisis service had its own fire and environmental risk assessments, both of these were up to date. The environmental risk assessment rated risk as high medium or low and referred to risks that were present within the building and risks that staff could encounter when visiting patients in the community, such as lone working.

The clinic room had the necessary equipment. There was a small clinic room which contained a fridge and cupboards for storing medicines. Staff checked the temperature of the clinic room and fridge daily and kept a record of this.

Staff made sure equipment was well maintained, clean and in working order. Equipment for monitoring patient observations such as blood pressure and weight was not present in the clinic room during our visit. Staff members had taken this equipment with them for visits. Administration staff kept a log of physical observation equipment and were responsible for ensuring equipment was calibrated correctly.

All areas were clean, well maintained, well furnished and fit for purpose. Staff had access to a kitchen and a wellbeing room. The wellbeing room was set up for staff during the COVID-19 pandemic and was an area that staff could use to relax. It contained sofas, books, an exercise bike, posters and leaflets containing relevant information for staff.

Staff made sure cleaning records were up-to-date and the premises were clean. All areas appeared clean and tidy.

Staff followed infection control guidelines, including handwashing. Handwashing signs were displayed above sinks. Staff wore face masks in line with current infection control guidelines.

Safe staffing

The service did not always have enough staff. The number of patients on the caseload of the mental health crisis teams, was sometimes too high to prevent staff from giving each patient the time they needed. However, staff received basic training to keep people safe from avoidable harm.

Mental health crisis services and health-based places of safety

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. The provider told us that CAMHS and adult crisis teams had different staffing requirements. The CAMHS crisis team worked between 8am and 8pm. The duty workers in the adult crisis team responded to CAMHS crisis calls outside of these hours. The provider told us that the adult crisis team should have a minimum of 10 staff during the day shift and two staff during the night shift. There was also an additional staff member who worked a twilight shift, between 2pm and 2am. We reviewed six months of staffing data between January and July 2022 and found that 54% of day shifts did not have the required number of staff. Managers told us that they increased staffing when the total crisis caseload exceeded 90. We reviewed the weekly caseload figures for this period and found that the adult crisis team caseload was above 90 for 23 out of 30 weeks (77%). We looked at staffing levels on the dates when the caseload was reviewed and found that there were not enough staff on 42% of occasions. For example, the caseload peaked at 142 on 7 March 2022, the staffing rota showed that there were only 11 staff on duty on this date, nine were on the day shift and two were on the night shift.

The provider told us that the CAMHS crisis team should have three qualified nurses and one support worker per shift. In addition to this, a qualified nurse was co-located with a psychiatric liaison team at a local hospital five days per week. We reviewed six months of staffing data between January and July 2022 and found that 88% of day shifts had enough staff. Staff from the health-based pace of safety had been redeployed to the crisis team after it closed on 6 June 2022. This increased the overall number of staff in the CAMHS crisis team. Staff who worked in the CAMHS crisis team told us that staffing levels had improved since the closure of the health-based place of safety.

The service had high but reducing vacancy rates. The service had a total of 25 vacancies, 20 of these were registered nurse vacancies. The provider had recently appointed eight registered nurses and were waiting for these nurses to start. Recruitment to the remaining vacant posts was ongoing. The adult crisis team had one team manager in post at the time of our inspection. A second manager post had been created due to the needs of the service, the team was in the process of recruiting to this post. The existing team manager told us that they felt well supported by the urgent care leads in the meantime.

The service had high rates of bank and agency nurses. The overall bank and agency fill rate for between January and March 2022 was 75%. The service used regular bank and agency nurses to fill some of the vacant posts. The service had low rates of agency nursing assistants. The service had one regular agency nursing assistant who was familiar with the service. The service did not use bank nursing assistants. Managers requested bank and agency staff who were familiar with the service. Bank and agency staff knew the service well and many had worked there for a number of years.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. One agency staff member told us that they had received an induction pack which contained relevant information about the service and contact details, they also spent a week shadowing experienced staff before they were expected to undertake lone working. Managers told us that the shadowing period could be extended if needed.

The service had high turnover rates. The average staff turnover rate was 26% between April and June 2022. The trust completed exit interviews with staff to understand their reasons for leaving.

Managers supported staff who needed time off for ill health. Staff told us that they worked together to cover colleagues' workloads when they were off work due to ill health.

Levels of sickness were high. The average sickness rate was 16% between April and June 2022. Three staff were off work due to sickness at the time of our inspection. Managers told us they had seen a recent increase in sickness due to COVID-19 and stress-related sickness.

Mental health crisis services and health-based places of safety

Managers used a recognised tool to calculate safe staffing levels. Senior leaders sent a 'situational report' to managers in each area of Forward Thinking Birmingham, including the crisis service, three times per day. The report identified the overall caseload number for each area and allowed managers to see which areas had high caseloads. The crisis service adjusted its staffing numbers based on how high the team caseload was. However, the staffing rotas showed that the adult crisis team was often short staffed despite this.

The number and grade of staff did not always match the provider's staffing plan.

Medical staff

The service had enough medical staff. The adult crisis team had three consultant psychiatrists and two specialist doctors. The CAMHS crisis team had one consultant CAMHS psychiatrist and one specialist doctor. The CAMHS crisis team had fewer medical staff as the caseload for this team was much lower than the adult crisis service. Staff told us that they could contact medical staff when they needed to. We saw that medical staff attended the weekly multidisciplinary team meetings.

Managers could use locums when they needed additional support or to cover staff sickness or absence. The service had three vacant medical posts. Two locum junior doctors and one locum psychiatrist provided cover. The service was in the process of recruiting to these vacant posts.

Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to. Staff told us that they had easy access to psychiatrists and were able to request urgent medical reviews for patients when they were needed. We saw that psychiatrists attended the weekly multidisciplinary team meetings. Staff told us that they could easily contact the on call doctor in the evenings and at weekends.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Staff compliance with the mandatory training programme was 92%. Compliance for individual training courses ranged from 86% to 100%. The mandatory training programme was comprehensive and met the needs of patients and staff. The mandatory training programme included courses such as Safeguarding, Mental Health Act, Equality Dignity and Diversity and Information Governance. Staff told us that they had enough time to complete their mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received emails to tell them when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient when they were allocated to the crisis service, using a recognised tool. However, staff did not always review this regularly, including after any incident. We reviewed the care records of six patients. In each of the records we reviewed, we saw that all patients had a risk assessment in place shortly after coming into the service. Managers told us that risk assessments were completed following the initial contact with patients and

reviewed at every contact after this. Five out of the six risk assessments we reviewed were updated following incidents or to reflect a change in need. However, we found that one patient's risk assessment had not been updated since a recent hospital admission or following a visit from staff whereby vulnerabilities were identified. We raised this with the manager, who told us the patient would be visited again the following day and the risk assessment would be updated.

Staff used a recognised risk assessment tool. Staff used the risk assessment tool on the electronic patient note recording system.

Staff could recognise when to develop and use crisis plans according to patient need. We saw that patients had a crisis plan in place where this was required. Staff discussed patients' crisis plans during weekly multidisciplinary team meetings and daily huddle meetings.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff discussed patients during daily huddle meetings and identified those who required an urgent contact or visit. The shift coordinator prioritised contacts for patients whose health had deteriorated. There was a process in place to follow up on patients who had not attended their appointments. The shift coordinator made sure that those patients were prioritised for another visit the following day.

Physical health was discussed during daily huddle and weekly multidisciplinary team meetings. We saw evidence that staff monitored physical health for patients who required this in the care records we reviewed.

Staff followed clear personal safety protocols, including for lone working. Staff discussed lone working procedures and identified if any visits would require a joint visit during daily huddle meetings. We observed one staff member calling a colleague to arrange a joint visit for later on in the day. Staff told us that joint visits were facilitated where this was necessary to keep them safe. The shift coordinator wrote the names of staff attending home visits on a whiteboard and kept this updated, so they knew where staff were throughout the day. Duty workers in the office called staff out on visits at midday, 3pm and 5pm every day to ensure they were safe. All staff completing home visits were aware that they could seek support in an emergency by calling the duty worker and stating a code word, which was known by all staff. The manager told us that the service had also ordered personal alarms and staff would be trained to use these when they arrived.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff were required to complete level one and level two safeguarding training, for both children and adults. Qualified staff members were also required to complete safeguarding level three training.

Staff kept up-to-date with their safeguarding training. We reviewed staff training data for July and found that 96% of staff had completed safeguarding level one training, 92% of staff had completed safeguarding level two training and 96% of all eligible staff had completed safeguarding level three training.

Mental health crisis services and health-based places of safety

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Ninety-two per cent of staff had completed equality and diversity training. We saw that staff had recorded the preferred name of one patient within their care records. Staff sensitively considered issues around gender identify for a patient during a multidisciplinary team meeting.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff gave us examples of when they had taken phone calls from children and young people at risk of immediate harm and had worked as a team to gather information from the person on the phone while a colleague contacted the emergency services. Safeguarding issues were discussed at the weekly multidisciplinary team meeting and daily huddle meetings. Managers attended a monthly safeguarding meeting with Birmingham Women's and Children's NHS Foundation Trust.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff understood the referral process and gave examples of referrals they had made. Staff told us that they could approach managers or the safeguarding team at Birmingham Women's and Children's NHS Foundation Trust to discuss safeguarding concerns and to get advice if needed.

Managers took part in serious case reviews and made changes based on the outcomes. For example, a recommendation from a recent serious case review was to improve the provision of psychological therapies across Forward Thinking Birmingham. The crisis team recruited a psychologist in response to this. The psychologist identified the therapeutic needs within the team and developed a strategy to meet these needs.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. All staff had access to the electronic patient note recording system. Staff had access to laptops so they could review and update patient records during visits. We reviewed six patient records and found these to be detailed and up to date.

When patients transferred to a new team, there were no delays in staff accessing their records. Some patients were referred to the crisis team from the psychiatric liaison team which was part of another local NHS trust. This team used a different system to store patient records. Staff called the psychiatric liaison team when they needed information about patients and told us they could access the information they needed.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed good practice in medicines management. We saw that staff counted patients' medicines during home visits to ensure that patients did not stockpile medicines. A pharmacist visited the service to complete an audit of the clinic room every two weeks. Staff told us that they could easily contact a pharmacist by phone if they had any queries regarding medicines. Managers completed a monthly audit of patient prescription cards to ensure these were accurately completed.

Mental health crisis services and health-based places of safety

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff told us they could easily contact medical staff to request a medicine review. Psychiatrists completed regular medicine reviews with patients. Staff also reviewed patients' medicines during weekly multidisciplinary team meetings. We saw that staff checked that patients had enough medicines and discussed potential side effects of medicines with patients during home visits.

Staff completed medicines records accurately and kept them up-to-date. We reviewed the prescription charts for 14 patients and saw that these were accurate and up to date.

Staff stored and managed all medicines and prescribing documents safely. Treatment cards were stored in the clinic room. Staff kept a record of when a treatment card had been removed from the treatment room and by whom. Medicines were stored in the clinic room. All medicines in stock were in date. A pharmacist from Birmingham Women and Children's NHS Foundation Trust completed an audit of the treatment room every two weeks and delivered medicines to the service when needed.

Staff followed national practice to check patients had the correct medicines when they moved between services. We saw that staff sent a letter to patients GPs when they were discharged from the crisis service which outlined any medicines they were prescribed. Patients were discharged with no more than two weeks' worth of medication.

Staff learned from safety alerts and incidents to improve practice. Managers shared learning from incidents with staff during daily huddle meetings and weekly multidisciplinary team meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed 14 prescription charts and saw that patients were not over prescribed antipsychotic medicines. Staff discussed patients' medicines at the weekly multidisciplinary team meeting and completed individual medicine reviews with patients when these were required.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Staff asked patients if they were experiencing any side effects during visits and advised patients on how to manage these. Staff monitored patients' physical observations and requested physical health checks such as blood tests and electrocardiograms (ECGs) for patients when needed. Staff counted patients' medicines during visits to make sure they did not have excessive amounts in stock at any time.

Track record on safety

The service had three serious incidents in the past 12 months. Two of these related to the deaths of patients in the adult crisis team. We saw that a serious incident investigation had already been completed for one of these incidents and an investigation was due to commence for the second incident. The lessons learnt from the first serious investigation had been shared with staff and we saw that the service had started to implement some of the recommendations from this.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff used an electronic incident reporting system to report incidents. All staff had access to this system. Staff reported serious incidents clearly and in line with trust policy. We saw that serious incidents were appropriately reported and categorised on the incident reporting system.

Mental health crisis services and health-based places of safety

Staff raised concerns and reported incidents and near misses in line with trust policy. One staff member told us how they used the incident reporting system to report an issue they had with accessing the patient care record system. They told us that this was quickly resolved and they received feedback.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw a patient's family was supported by a Family Liaison Officer following a recent serious incident investigation and managers met with family members as part of the investigation process.

Managers debriefed and supported staff after any serious incident. Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Managers informed staff about serious incidents in team meetings and in the crisis service newsletter. The psychologist also offered debrief sessions to staff following incidents and was in the process of creating a formal debrief process.

There was evidence that changes had been made as a result of feedback. A recent serious incident report recommended that Forward Thinking Birmingham completed a review of its psychology provision and improved staff awareness of the role of psychological therapies in providing holistic support to patients. The crisis service had recruited a clinical psychologist based on this recommendation. The psychologist had developed a psychological strategy for the crisis team and had reviewed reflective practice arrangements, post-incident support and had planned some specialist therapeutic training for staff.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans but did not always update them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. However, care plans did not always show evidence of ongoing physical health monitoring for patients who had physical health needs.

Staff completed a comprehensive mental health assessment of each patient. Staff aimed to visit patients to complete an assessment within four hours after being referred into the team, or within 24 hours if the psychiatric liaison team in hospital had already completed an assessment for those who had attended the accident and emergency department. We reviewed six patient care records and found that staff had completed a comprehensive patient risk assessment for each patient.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Staff completed physical health checks as part of the crisis assessment, for patients who required this. Staff told us that they monitored patients' physical observations if they were prescribed medication for their mental health. Staff recorded information about physical health conditions in patients' care records and we saw that staff had recorded physical health alerts for some patients with known and potentially serious health conditions, such as allergies and high blood

pressure. Staff discussed patients' physical health needs in weekly multidisciplinary team meetings and we observed that staff monitored one patient's physical observations during a home visit. We reviewed six patient records and found that staff had developed a comprehensive mental health care plan for each patient. Staff completed monthly audits of the quality of patient care plans and had identified some areas for minor improvement with regards ongoing physical health monitoring which they had plans to rectify.

Staff reviewed and updated most patients' care plans when their needs changed. Of the six patient records we reviewed, we found that staff had regularly reviewed and updated these for five patients. However, one young person's care plan had not been updated following a recent hospital admission and their care plan did not reflect the patient's current living arrangements or current risks. We raised this with the service manager, who addressed this at the time of inspection.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. Staff completed assessments, care plans, risk assessments and crisis plans with patients. Staff also provided advice around managing mental health needs and also around other issues such as bereavement. Staff provided home visits and telephone contacts to patients, depending on their level of need. Staff discussed the level of contact needed for each patient during daily huddle meetings and recorded this on a board in the office for all staff to see. Staff prioritised patient contacts based on the level of need and ensured that all urgent visits were completed. We saw that staff also referred and signposted patients to other services such as the Living Well Consortium, which provided psychological therapies.

The crisis team were in the process of developing a therapeutic programme for patients. The psychologist had arranged various staff training sessions for therapeutic interventions due to take place in August and September 2022.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Staff booked patients in for health checks such as blood tests and electrocardiograms (ECGs) with local hubs when required.

Staff did not always support patients to live healthier lives by supporting them to take part in programmes or giving advice. We reviewed care plan audit data for the past five months and found that only 12 out of 23 patients had been signposted to health promoting services.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Staff used technology to support patients.

Mental health crisis services and health-based places of safety

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers completed a monthly Mental Health Quality Improvement (MHQI) audit. Areas including risk assessments, care plans, safeguarding, physical health and medicines were included in this monthly audit. Managers discussed the results of audits in monthly clinical governance meetings.

Managers used results from audits to make improvements. For example, care plan audit results showed care plans did not always evidence that staff had monitored patients' physical observations or that staff had offered patients a copy of their care plan. We observed that a manager had reminded staff to update physical observations and offer patients their care plan during a daily huddle meeting.

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. However, staff told us that their access to clinical supervision had been impacted by low staffing levels. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients. The crisis service consisted of registered mental health nurses, nursing assistants, consultant psychiatrists and specialist doctors. The service had appointed a clinical psychologist in October 2021. The psychologist supported both the CAMHS and adult crisis teams and attended multidisciplinary team meetings. The service was in the process of recruiting an assistant psychologist. The service did not have an occupational therapist and was reviewing whether there was a need for this.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. All new staff including bank and agency were given an induction pack which contained key information about the service. The CAMHS and adult crisis teams each had their own specific induction packs. New staff shadowed experienced staff before they were expected to undertake lone working. Staff members told us they had felt well supported during the induction process.

Managers supported staff through regular, constructive appraisals of their work.

Managers did not always support staff through regular, constructive clinical supervision of their work. We reviewed clinical supervision audit data from January until June 2022. Audits suggested that 100% of staff had received clinical supervision for each of these months. However, this did not reflect what staff and managers told us. Managers told us that supervision had been impacted by the low staffing levels in March and April 2022. One staff member told us that they had only received supervision three times in the past 12 months. Another staff member told us that they had not had supervision for a long time but had been able to have regular supervision once the staff from the health based place of safety had come into the team. They were concerned about what would happen when those staff returned. Another staff member told us they had not had formal supervision since they had started in the team.

However, staff told us that they could approach colleagues and managers for informal discussions outside of supervision. The service had also recently introduced group reflective practice sessions, these were led by the psychologist. Staff were aware of these sessions and attended them. Managers told us that the service was looking to re-introduce 'live supervision' sessions, where staff received feedback on their practice. These had stopped due to COVID-19.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers were supportive of the plans to deliver specialist training sessions to staff, each training course had several dates to enable as many staff to attend as possible. One staff member told us they had offered the opportunity to apply for the Nurse associate programme. Staff told us that they had enough time to complete their mandatory training.

Managers made sure staff received any specialist training for their role. The service had developed and had started to deliver a specialist training programme for staff in the crisis service. We saw that staff had recently received training on learning disabilities and autism spectrum disorder. Further specialist training was to be delivered in August and September 2022. The courses included attachment and developmental trauma, solution focused therapy, care planning sessions, motivational interviewing and substance misuse. Staff were aware of the planned training.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers told us they dealt with performance issues informally where this was possible and offered more support to staff to address these. Managers worked with staff and the human resources team to create an action plan to address performance issues and considered if staff required further support from the occupational health team.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation. However, they did not always have effective working relationships with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The CAMHS and adults crisis teams each had separate multidisciplinary team meetings. Both teams had three multidisciplinary team meetings per week to ensure all patients were discussed. These meetings were attended by team managers, nurses, healthcare assistants, and a consultant psychiatrist. The psychologist also attended some multidisciplinary team meetings to discuss particular patients.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff shared key information about patients' needs, risks medication and any safeguarding concerns during the multidisciplinary team meetings. Administration staff clearly documented multidisciplinary team discussions on a spreadsheet which was accessible to all staff and uploaded relevant information to individual patient records.

Ward teams had effective working relationships with other teams in the organisation. The CAMHS crisis team worked closely with the Children in Care team and invited them to multidisciplinary meetings. Staff also attended child in need and child protection meetings when needed. Managers attended a monthly meeting relating to safeguarding with Birmingham Women's and Children's NHS Foundation Trust. Managers told us they had good links to the community hub teams, however there was sometimes a delay in the hub teams being able to accept referrals from the crisis team due to low staffing levels. This caused the crisis team to support some patients for longer than they should have.

The crisis service did not always have effective working relationships with external teams and organisations. The majority of adult crisis referrals came from staff at the psychiatric liaison team which was part of another local NHS trust. This team was located in the local hospitals and completed mental health assessments for patients aged 18 to 25 who had attended A&E. Staff told us that sometimes they would receive referrals from the psychiatric liaison team which

did not meet the crisis service criteria. We spoke to staff in both the crisis service and the psychiatric liaison team and staff from both teams identified that there was poor communication between the teams at times. Managers in the crisis service planned to arrange a meeting with senior managers in the psychiatric liaison team to discuss the current referral process and criteria. However, the crisis team worked effectively with other external teams. For example, it worked closely with a local supporting housing charity and met with this team once a month. This charity supported young people aged 16-25 who were at risk of becoming homeless.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. We reviewed mandatory training data for July 2022 and saw that 88% of staff had completed Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff knew how to contact the trust's Mental Health Act administrators.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. Information about advocacy services was displayed on the trust's website. However, managers told us there was not a high need for advocacy in the crisis service as the many patients open to the crisis service were not detained under the Mental Health Act and many had support from parents and carers.

Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We observed one visit where a young person told their doctor that they wanted to leave their temporary accommodation and that staff could not prevent them from doing this as they were an informal patient. Informal patients are those who are not detained under a section of the Mental Health Act and means that they are free to leave. The doctor did not clearly explain to the young person what their rights were under the Mental Health Act, which could have caused some confusion for them. We reviewed the patient's care records after the visit, these did not identify that the patient had stated that the young person had said that they wanted to leave.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Mental health crisis services and health-based places of safety

We asked the trust to provide Mental Capacity Act training figures for the crisis service but they did not provide this information. However, the staff we spoke with in the crisis service had a good understanding of the five Mental Capacity Act principles. Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Staff knew how to apply the Mental Capacity Act to patients aged 16 and 18 and where to get information and support on this.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew how to access the Mental Capacity Act policy on the trust intranet page.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff recognised and respected when patients had the capacity to make decisions for themselves.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Audit data showed that staff recorded consent in 22 out of 25 (88%) of patient records.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw that staff had involved patients and family members in decisions where the patient lacked capacity to make the decision for themselves.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, staff did not always support patients and carers to access other services when they needed help.

We observed staff and patient interactions during five home visits. We saw that staff were discreet, respectful, and responsive when caring for patients. We saw that staff spoke to patients with empathy and offered appropriate support.

Staff gave patients help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care treatment or condition. We saw staff gave advice and support to patients around bereavement, sleep hygiene and anxiety. Staff made sure that patients had the crisis team number, so they could access support out of hours or in between staff visits.

Mental health crisis services and health-based places of safety

Staff directed patients to other services but did not always support them to access those services if they needed help. One carer told us that staff had planned to refer their family member to the community hub team but this had not happened yet. Staff told us that there was sometimes a delay in the community teams picking up cases. The carer told us that the crisis and home treatment teams had kept in touch with them while they waited for support from the community hub team. Another carer told us that they felt the crisis service did not always provide the right support at the right time. They explained that the crisis team had been involved with their family member on various occasions over a number of years but they had not explored whether their family member would benefit from the support of the home treatment team. The home treatment team provides support for patients who need a higher level of support for up to eight weeks.

Patients said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each patient. One patient told us that the staff member who had visited them was caring, understood and took time to listen. Carers told us that staff were kind and listened to them and their family member.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Staff used laptops to record patient notes while out on visits and knew how to keep them safe.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed. However, they did not always make adjustments for patients' communication needs. Staff did not always give patients a copy of their care plan in a timely manner or inform and involve families and carers appropriately.

Involvement of patients

Staff involved patients but did not always give them timely access to their care plans. Care plan audit data for the past five months showed that five out of 25 (20%) care plans did not contain evidence that staff had offered a copy of the care plan to patients or parents of children and young people. Three out of the five carers we spoke to told us that staff had not provided their family member with a copy of their care plan when it was first created. One carer told us that they had not been aware of the actions in the care plan when they had eventually received this. However, during a visit we observed a staff member give a copy of a care plan to a young person and their carer and go through this with them.

Staff made sure most patients understood their care and treatment but did not always find ways to communicate with patients who had communication difficulties. One carer told us about a negative experience where a staff member had not adjusted their communication style to suit their family member who was autistic and had asked them lots questions, which the family member had found overwhelming.

Staff involved patients in decisions about the service, when appropriate. The trust had a young persons' advisory group called 'Think4Brum'. The Crisis team had planned to have a focus group with the patient advisory group to get feedback on the planned therapeutic group sessions for patients.

Patients could give feedback on the service and their treatment and staff supported them to do this. We saw that staff informed patients and carers of how they could make a complaint if they were not happy with the service. Managers told us that it was sometimes difficult to get feedback from patients and carers, especially if they were experiencing crisis. Staff used an initiative called 'Friends and Family Test Friday' to try and collect more feedback.

Mental health crisis services and health-based places of safety

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Staff supported patients to access advocacy when it was needed.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always inform and involve families or carers in a timely manner. Two carers told us that they did not know what the plan was for their family members. One carer told us that staff had told them that their family member would be referred to the community hub for long term support but they had not heard anything further about this and was concerned about the lack of progress. However, the carer told us that their family member had a recent care and treatment review and they were now hopeful that progress would be made. Three out of five carers told us that they had not initially been provided a copy of their family members care plan when it was first created but they had since been provided with this.

Staff helped families to give feedback on the service.

Staff did not always give carers information on how to find the carer's assessment. Two support workers we spoke with did not know what a carers assessment was. Four out of five carers we spoke with had not been told about the carers assessment. However, the CAMHS crisis team signposted carers to the 'Young Minds' website, which provided a webchat and telephone advice and support service for parents and carers.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access, including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service had clear criteria to describe which patients they would offer services to. The crisis service was available to children and young people up to the age of 25 and had a three part admission criteria which detailed the reason for, and level of support required.

However, the psychiatric liaison team told us that sometimes the crisis service had been reluctant to accept referrals from them. Staff at the crisis service told us that sometimes the psychiatric liaison team referred people who did not meet the criteria as they were not at immediate risk of harming themselves or others. Managers told us that they had looked at the referrals made by the psychiatric liaison team and found that 70% of referrals resulted in two or fewer sessions with the crisis team. Managers told us that they thought this meant that the young person may not have needed support from the crisis team. However, the crisis service was designed to be a short-term service and usually

only supported children and young people for between two and four weeks before referring onto other services, suggesting it would not be unusual for a child or young person to only need support from the crisis team for a short time. Managers in the crisis team told us that they planned to meet with managers in the psychiatric liaison team to consider how to improve the referral pathway.

The trust set and the service met the target times seeing patients from referral to assessment and assessment to treatment. Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. New patients were expected to be assessed within four hours of being referred to the crisis service, unless they had already been assessed by the psychiatric liaison team. In this case, patients were seen the following day. Managers attended a weekly urgent care meeting where they reviewed whether patients were being seen within this timeframe. Managers told us that they met these target times. Shift coordinators told us that they had to constantly review the workload allocations to staff, to ensure they could prioritise any urgent referrals that were received. The CAMHS team had a nurse based in a psychiatric liaison team at one of the local hospitals to ensure they could complete timely mental health assessments of children and young people who attended A&E.

The crisis team had skilled staff available to assess patients immediately 24 hours a day seven days a week. Crisis referrals made before 5pm during the week were dealt with by the Referral Management Centre. This team dealt with all of the new referrals into Forward Thinking Birmingham. Staff would refer calls to the crisis service if they felt the call met the crisis criteria. The crisis shift coordinator and duty workers dealt with referrals after 5pm and at weekends. Staff used whiteboards in the office to track new crisis referrals. The shift coordinator allocated staff to complete visits or telephone calls to patients and recorded this on the whiteboard.

The team responded quickly when patients called. Carers told us they were able to get through to the crisis team when they needed to. We saw staff answering calls from patients in a timely manner. However, the crisis service did not monitor how long it took callers to get through.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Carers told us that some staff worked hard to understand the patient and their communication needs, but their family members sometimes found it difficult to engage with staff as they often saw new staff at each visit. One carer told us that the manager had become their point of contact when their family member was experiencing crisis and that the manager was helpful and reassuring.

The team tried to contact people who did not attend appointments and offer support. Staff followed up when patients had not been in contact or had missed a planned appointment. We saw one staff member tried to call a patient who had not confirmed their planned appointment. The staff member still tried to go ahead with the visit, despite the patient not responding. Staff discussed all patients who had not attended their appointment or who had not been contactable each day at the handover meetings. We saw that staff on the following shift attempted to make contact with the patient again. The crisis service had a procedure in place for following up missed appointments and telephone calls, this was displayed on the whiteboard in the office.

Patients had some flexibility and choice in the appointment times available. The shift coordinators tried to arrange planned appointments for times that were suitable for the patient, but sometimes appointments had to be rearranged based on staffing levels or if urgent assessments needed to be completed.

Staff sometimes had to cancel appointments. Less urgent appointments had to be cancelled when the service was short staffed as staff had to prioritise urgent assessments on these occasions. The crisis service shift coordinator would use the information contained within the referral and from their initial telephone contact with patients to assess the level of urgency and to decide how many and what type of contacts patients needed. This was also discussed in the daily huddle. The shift coordinator called patients to rearrange any cancelled appointments.

Appointments ran on time and staff informed patients when they did not. Staff called patients ahead of visiting them to check they were still available.

The service used some systems to help them support patients. The adult crisis service used an online dashboard to monitor the number of patients open to the service each month and allowed staff to compare crisis caseloads with the previous year. The CAMHS crisis team kept a separate spreadsheet of the outcome of referrals. However, the service did not monitor how long it took people to get through to the crisis service and it did not monitor how many times a child or young person had been referred to the service. One carer told us that their family member had been referred to the crisis service by various agencies over seven times before the referral was accepted.

Staff supported patients when they were referred and transferred between services. There were some delays in patients being transferred to the community hub teams due to waiting to be allocated to a care coordinator. The crisis team remained involved and continued to contact these patients until they were allocated to a worker. One carer told us that their family member had regular calls and visits from the crisis team while they were waiting for a care coordinator to be allocated. However, one carer told us that they had experienced a lack of coordination between the crisis service and hospital staff when their family member had been admitted to hospital. The psychiatric liaison team told us that they would like the crisis service to maintain their involvement when one of their patients is admitted to hospital. We heard about one patient who had been assessed by the crisis service but had been taken to hospital due to staff being unable to find a community bed. The psychiatric liaison team told us that the staff from the crisis service had not been to see the patient despite awaiting a bed for several days.

The service followed national standards for transfer. Staff discussed the need to update patients' care plans and risk assessments before they transferred to a new team. Staff sent letters to patients and their GPs when they were discharged from the crisis service.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. The service had two staff offices and various meeting rooms. The service also had a staff wellbeing room. The crisis service did not have any interview rooms as staff visited patients in community settings such as their home or school.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work and supported patients. Staff spoke with patients about their aspirations for the future. We saw that staff liaised with family support workers for a young person who was not attending school.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Mental health crisis services and health-based places of safety

Meeting the needs of all people who use the service

The service did not always meet the needs of all patients – including those with a protected characteristic. Staff did not always help patients with communication. However, they did help patients with advocacy and cultural and spiritual support.

The service did not always support and make adjustments for disabled people and those with communication needs or other specific needs. One carer told us that their family member had struggled to communicate with some staff as the staff who visited were different most of the time. Another carer told us about a negative experience where a staff member had not adjusted their communication style to suit their family member who was autistic.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff informed patients and carers of how they could make a complaint. The carers we spoke with knew how to raise their concerns if they needed to.

The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The crisis service had received 12 complaints from patients and carers in the past 12 months. Ten complaints had been closed, one complaint was ongoing and one complaint had no outcome recorded.

Staff understood the policy on complaints and knew how to handle them. Staff knew to tell patients and carers how they could raise concerns if they were not happy about the service. We saw that one staff member explained to a patient and carer how they could make a complaint during a home visit.

Managers investigated complaints and identified themes. Managers told us that complaints were usually in relation to patients feeling that they did not get the care they had expected, or the patient being unhappy about the outcome of crisis service involvement. Staff told us that it was sometimes difficult to get feedback from patients and carers who were experiencing a crisis. Managers had recently started an initiative to gather feedback from patients and carers every Friday by giving out a barcodes that patients and carers could scan with their mobile phones to access the survey webpage.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients and carers received feedback from managers after the investigation into their complaint. One carer told us that they had made a formal complaint about their family member's care and they had received a full response.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback was shared with staff during team meetings and in the weekly crisis team newsletter.

Mental health crisis services and health-based places of safety

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The crisis service had two urgent care leads, one for the CAMHS crisis team and one for the adults crisis team. The adult crisis team was supposed to have two team managers but had one vacancy. The team was in the process of recruiting a second team manager. The existing team manager told us that they felt well supported by the urgent care leads in the meantime. Managers of the crisis service knew about the key issues affecting the service. For example, managers understood how periods of low staffing and high sickness had affected staff workload. Managers had also considered how staffing levels may be impacted by the reopening of the health-based place of safety and had developed contingency plans for both the crisis teams and health-based place of safety in response to this. Staff told us that managers were approachable and supportive.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff knew the trust's values of Ambitious, Brave and Compassionate, these were displayed in the crisis service. We saw that staff were compassionate in the way they treated patients and carers told us individual staff members were kind and caring.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us that managers were respectful and supportive and that they could approach any manager or member of the team for support. Staff had opportunities to progress and we saw that staff had been promoted since joining the crisis team. Staff knew how to whistleblow and felt able to raise their concerns without negative consequences. Staff had access to the trust's freedom to speak up guardian. Managers referred staff to the occupational health service and had arranged informal wellbeing drop in sessions for staff. Managers had implemented a 'wellbeing room' to give staff a space to take a break and reflect.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Mental health crisis services and health-based places of safety

Managers completed regular audits of care plans, risk assessments and safeguarding referrals, the results of these audits were discussed at weekly operational meetings and monthly governance meetings. Multidisciplinary meetings were well organised and followed a clear agenda to ensure essential information about patient risk was discussed. Staff recorded notes from multidisciplinary team meetings on a spreadsheet so staff could clearly see any changes in patient need and risk on a weekly basis. Changes in risk were discussed several times a day during handover and huddle meetings.

The crisis service had recruited a psychologist, developed a psychological strategy and developed a specialist staff training programme to improve patient access to therapeutic input, based on recommendations from reviews of deaths and incidents.

However, the crisis service did not always work effectively with the psychiatric liaison team based in hospitals. Staff in the crisis service told us that they sometimes received inappropriate referrals from the psychiatric liaison team, but the psychiatric liaison team told us that there was little opportunity for staff to get advice from the crisis service or to discuss possible referrals. Managers in the crisis service told us that they planned to arrange a meeting with senior leaders in the psychiatric liaison team to discuss ways that they could work more effectively together.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register at team and directorate level. Risks identified on the risk register included recruitment and retention of staff, the health-based place of safety being temporarily closed due to low staffing and delays in transferring patients from the crisis service to the community hubs and early intervention service. These risks matched the concerns that staff told us about. Forward Thinking Birmingham had a COVID-19 contingency plan which highlighted that the crisis service was a high priority service and would be supported to keep running in the event of a COVID-19 outbreak.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had access to the information they needed to complete their work. Staff completing visits in the community had access to a laptop so they could view and update patient records on the go. The telephone system worked well and patients, carers and professionals were able to call the crisis teams for advice and support when they needed to.

However, the crisis service did not monitor telephone waiting times. This meant it was not possible to know how long people had to wait to get through to the service.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers in the crisis service regularly attended governance and safeguarding meetings with the wider NHS trust. Managers had effective working relationships with the local Children in Care team, emergency services, primary care services and a charity supported living provider to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting

Mental health crisis services and health-based places of safety

Managers had recognised that improvements could be made to the crisis service's engagement with the psychiatric liaison team based in hospitals and had plans to meet with leaders in this team to identify ways to do this.

Staff received up to date information about the service through the crisis service newsletter, trust intranet and team meetings.

The crisis service was working to improve opportunities for patients and carers to give their feedback about the service and had introduced an initiative to gather more feedback. The crisis team also worked with the patient engagement group 'Think4Brum' to seek children and young peoples' opinions about proposed treatments.

Forward Thinking Birmingham engaged with external stakeholders including commissioners and Healthwatch.

Learning, continuous improvement and innovation

The crisis service had recruited a psychologist to complete a review of the therapeutic offer and of how serious incidents were dealt with. The psychologist delivered reflective practice group sessions to staff to discuss and reflect on incidents and was in the process of developing a formal debrief programme. Managers had developed a crisis service newsletter to ensure that key information and lessons learnt from incident was shared with all members of staff.

Specialist community mental health services for children and young people

Inadequate ↓

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as Inadequate.

Safe and clean environments

Clinical premises where patients received care were not always safe, clean, well equipped, well furnished, well maintained or fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and there were plans to remove or reduce any risks they identified. The provider had identified that the buildings in the South hub (Oaklands) and East hub (Blakesley) were not fit for purpose and were identifying other potential sites to relocate to. In the interim they had assessed the environmental risks and assessments stated how the risks were to be reduced. For example, at Oaklands anti–ligature door closures were to be fitted and windows were to be replaced. We saw Estates staff were boxing in pipes at Oaklands to reduce ligature risks. However, waiting rooms at all three sites were shared by adults and children and they used the same clinical rooms. At Oaklands there was a separate toilet for children opposite the therapy rooms.

Staff had easy access to alarms and people who used the service and visitors had easy access to nurse call systems. All interview rooms had alarms and staff available to respond apart from the newly refurbished sensory room at Oaklands although this was planned. The alarms were portable so could be moved between rooms. The alarm hubs were in reception offices and the portacabin at Oaklands and these showed the room where the alarm was sounding. Staff tested the alarms weekly. Staff told us of a previous incident where an alarm was found not to be working, this was taken out of use and repaired.

We found at Blakesley there were no ligature cutters available to use in an emergency and we raised this with the provider. These were obtained and available the following day and staff were trained in their use.

Maintenance, cleanliness and infection control

All areas were clean, well maintained, well furnished and fit for purpose. However, some clean stickers (applied when an area has been cleaned) were dated April and May 2022. At Oaklands the clinical waste bin in the clinic room was full and the sharps bin that stated it was full since 7 April 2022 was still in the clinic room and had not been collected for disposal.

Staff did not make sure cleaning records were up to date. Cleaning records that stated what had been cleaned and what needed to be cleaned were not available. Staff had ticked to say the clinic room had been cleaned but it was not clear what equipment had been cleaned and when.

Staff always followed infection control guidelines, including handwashing. The trust had reviewed its guidance to staff in relation to national guidance for Covid-19 and the wearing of masks in non-clinical areas was optional. We observed most staff to not be wearing masks in non-clinical areas however they always asked inspection staff if this was okay and if not, they wore a mask while in the room.

Clinic room and equipment

Clinic rooms were fully equipped. All clinic rooms had the necessary equipment for people who used the service to have thorough physical examinations. Staff made sure equipment was well maintained, and in working order. However, at Oaklands in one clinical room there was no evidence that the weighing scales had been calibrated.

Safe staffing

The service did not have enough staff, who knew the people who used the service to keep them safe from avoidable harm. Staff received basic training although did not receive specialist training in working with children and young people in mental health services. The number of patients on the caseload of the teams, and of individual members of staff, did not ensure that staff gave each person who used the service the time they needed.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe as there were a number of staff vacancies. In the East hub they had a 1.6 whole time equivalent registered nurse vacancy and one vacancy for a Clinical Team manager. These vacancies were managed through the use of long-term agency staff. In the West hub there was one full time band 6 registered nurse vacancy and one community support worker vacancy. In the North hub there were vacancies for a 0.6 band 6 and a 0.97 band 5 registered nurse. In the South hub there were two full time band 6 registered nurse vacancies. Nursing staff said the vacancies impacted on people being allocated a care coordinator. Some patients were allocated to therapists, but their role meant they could not care coordinate for patients with complex needs. However, all posts had been advertised and the service had low rates of bank and agency nurses and community support workers.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. However, the number and grade of staff did not match the provider's staffing plan. Registered nurses who were care coordinators had an average caseload of 27 people. Staff said it was difficult to manage a caseload as well as cover the duty calls and visits. This meant that sometimes they did not have sufficient time to spend with the people who used the service.

Managers had recognised that they needed to recruit more staff and at the time of our inspection were recruiting in South Africa.

There were vacancies across the teams for other staff including therapy staff. In the North team the occupational therapist post had been filled. In the West team there was a vacancy for an advanced practitioner and one psychology post was unfilled whilst a member of staff was on maternity leave. In the South team there were 1.8 whole time equivalent vacancies for psychologists and one psychology assistant. Staff told us that the staff shortages in the West team impacted on the North team. These two teams were both based at Finch Road. Staff said that if there was a need to support a person using the service but no staff from the West team were available, staff from the North team had to support the person. There were 2 family therapist vacancies in the East and North teams.

There were also administrative staff vacancies across all four teams. These posts had been advertised and at the time of inspection were filled by bank staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates. The average turnover rate across the four community core teams was 20% in May 2022, and in June 2022 at the time of inspection remained the same. The provider had recognised that retention of staff was a risk, and this was an item on the providers risk register. Staff told us they were leaving because they were expected to do Choice assessments (initial meeting where staff talk with the child or young person, listen to their symptoms and decide how to help them) and manage caseloads which felt unsafe.

Staff said managers supported them if they needed time off for ill health. The levels of sickness rates across the core community services were reducing. In April 2022 they were 4%, May 2022 at 2.9% and in June 2022 at the time of inspection were 2.3%.

Medical staff

The service did not have enough medical staff. In the East team there were two whole time equivalent vacancies for CAMHS consultant doctors and in the West team there was a vacancy for a specialist registrar and a middle grade doctor. This meant the average case load for a doctor was higher than expected at 135. We saw that some children and young people waited for over six months to have a review by a doctor. Managers could use locums when they needed additional support or to cover staff sickness or absence. Managers made sure all locum staff had a full induction and understood the service.

In the West team there was a vacancy for a consultant psychiatrist for people aged 18 to 25 years. This was covered by a locum who did not work there regularly. In the North team there was a vacancy for a consultant psychiatrist for people aged 18 to 25 years. The provider was unable to get a locum to cover this post, so it was covered by an agency middle grade doctor. This meant the average case load for a doctor was higher than expected at 135. We saw that some patients waited for over six months to have a review by a doctor.

However, the service could get support from a psychiatrist quickly when they needed to as this was covered by the Crisis teams who had psychiatrists who were specialists in CAMHS and adults. Additionally, the trust told us that following inspection a locum position was substantively filled.

Mandatory training

Staff had not completed and kept up to date with their mandatory training. The provider told us that the overall mandatory training compliance figure was 69% in May 2022. On average only 18% of staff had completed training in Child Sexual Exploitation as of May 2022.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they were alerted via the electronic system when their training needed to be updated.

Assessing and managing risk to patients and staff

Specialist community mental health services for children and young people

Staff did not assess and manage risks to people who used the service well. They did not always respond promptly to sudden deterioration in a person's mental health. When necessary, staff did not work with people who used the service and their families and carers to develop crisis plans. Staff did not always monitor people on waiting lists to detect and respond to increases in level of risk. However, staff followed good personal safety protocols.

Assessment of patient risk

Staff did not always complete risk assessments for each person who used the service, and did not review these regularly, including after any incident. We looked at 17 records of children and young people who were under 18 years old. We found in five of these records that risk assessments had not been updated to reflect a change in risk or did not include all identified risks to the individual. Two children and young people had been identified as 'lost to follow up', and staff had not had contact with either for 13 months. One young person's record did not contain a risk assessment from their appointment in August 2021, and they were still waiting for an appointment with the doctor.

Another young person's risk assessment was dated 30 October 2018 and had not been updated despite records of a clinic appointment stating there had been changes to risks of self-harm and suicidal thoughts. Another young person's record did not show that staff had assessed their risk of self-neglect.

We looked at 15 records of patients who were over 18 years old. Staff did not review these regularly, including after any incident. For example, one person's risk assessment had not been updated following an allegation of sexual assault, the previous weekend.

Staff did not always recognise when to develop and use crisis plans and advanced decisions according to patient need. For example, one patient's risk assessment was last updated in April 2019, despite a letter to their GP in February 2022 stating the person was at risk of suicide.

Another patient had not been seen by the team or had a risk assessment completed following referral which indicated a high risk. The patient telephoned the service as they had run out of medication, and they had missed an appointment as they did not receive notification of it.

Management of patient risk

Staff did not always respond promptly to any sudden deterioration in a person's mental health. Risk assessments were not updated in response to changing risk. For example, one person's risk assessment was last updated in March 2022. We observed a telephone call to the person and their carer during our inspection where they identified a risk of self-harm, but their risk assessment was not updated following the call.

Another person was discussed in the staff "daily huddle" on 22 June 2022 due to safeguarding concerns. Their risk assessment and care plan were last updated 12 April 2022 but was not updated since to reflect that their risks were reviewed and ongoing.

Another person's risk assessment was dated 2017 but there was no evidence that it had been reviewed or updated since. Another person's risk assessment completed in October 2020 highlighted several risks but there was no evidence that it had been reviewed since.

Another person's risk assessment dated January 2022 identified a risk from others. The patient had alleged they had been sexually assaulted the previous weekend, but their risk assessment had not been reviewed to reflect this.

Specialist community mental health services for children and young people

The trust identified that several people who used the service had been 'lost to follow up' and had commissioned a root cause analysis investigation into this. ('lost to follow up' meant that staff had lost contact with the person, that they did not have a next appointment and had not been allocated a care coordinator). Operations managers told us they estimated the number of children and young people 'lost to follow up' varied between 20 and 403 across the four locality teams. Operations staff were tasked with working through those that had been identified as 'lost to follow up' and showed us their plan for this. There had been a death of a young person in April 2022 who had been identified as 'lost to follow up'. From records we looked at we did not see that staff continually monitored people who used the service on waiting lists for changes in their level of risk and respond when risk increased.

Staff told us they discussed in the 'daily huddle' people who had not attended appointments the previous day. If a follow-up appointment was required, they were offered two further appointments then an opt in letter was sent. This meant that if the person did not make contact they were discharged from the service. Staff said most people were referred to the service from the Crisis team, so they already had information about them on records. Staff told us they would telephone those who did not attend, send an appointment letter and if no response was received then they would write to the young person's GP. Records showed that some people did not receive their appointment letter in time for them to attend.

Following our inspection, we requested immediate assurance from the trust that improvements be made with regards patient risk assessment and management and the trust responded to this with an immediate plan of action. We revisited the service between 10 and 11 October 2022 to review progress against this plan and found that whilst some improvements had been made, such as with regards review and management of incidents, there remained concerns about staff abilities to use the current patient electronic recording system to record patient risk assessment and management plans.

Staff followed clear personal safety protocols, including for lone working. All staff we spoke with were aware of the trusts lone working protocol and how it affected the work they did. They were aware of the need to sign in and out of the hub or to contact the hub if they were going to visit a patient from home. Staff told us about the 'purple folder' and who to contact if a staff member had not returned from a visit to a patient when they said they would. Staff discussed in 'daily huddles' visits to patients and any risks. Staff had access to lone working devices which linked to the police in an emergency. The provider had trained administration staff in Breakaway (low level physical intervention) following an incident where a person using the service broke a water cooler in the reception area.

Safeguarding

Staff understood how to protect people who used the service from abuse, but the service did not always work well with other agencies to do so. Staff had basic training on how to recognise and report abuse, but this needed to be more in depth. The provider had a named nurse and doctor for child safeguarding and adult safeguarding. The teams had a safeguarding lead.

Staff received training on how to recognise and report abuse. As at May 2022 87% of staff had received safeguarding adults training level 1, 79% level 2 and 83% level 3. 88% of staff had completed safeguarding children training level 1, 80% level 2 and 83% level 3. However, staff said that all safeguarding training had been online and to really understand it they needed this face to face. Following a serious incident, managers told us that safeguarding scenario face to face training was to be delivered to all staff by end August 2022 however, at the time of inspection this had not started, and staff were not aware of this.

Specialist community mental health services for children and young people

Staff did not know how to recognise adults and children at risk of or suffering harm and did not work with other agencies to protect them. One record showed that a young person was at risk of Child Sexual Exploitation and in April 2021 they had been reviewed and it was noted the young person was pregnant. They had no further contact with the service until May 2022 when it was identified they were 'lost to follow up'. Their records did not show any consideration of the risks to them or their baby. During our inspection we observed a telephone call with a person using the service who had a young child which identified that the person was at risk of self–neglect. There was no discussion about the welfare and safety of their child. One young adult's records indicated they were at risk of sexual assault. Staff had referred the person to the local Rape and Sexual Violence Project but had not referred to safeguarding.

Staff raised concerns that online coercive control from peers is common but is not included in safeguarding training. They also said that 'Think family' was not applied when assessing a child's mental health. For example, if there were any safeguarding reasons within the family that were causing the person to self-harm or attempt suicide the reasons for these behaviours were not explored.

Staff told us they worked with social workers and schools and would contact them if any safeguarding concerns. However, staff discussing a young person in a multidisciplinary team meeting did not know which school they went to. There was no evidence in the young person's records that trust staff had liaised with the school.

Staff knew who the named nurse for child safeguarding was and how to contact them. They said their number was displayed around the offices. We observed that where needed staff requested Child in Need assessments.

Staff knew how to make a safeguarding referral and who to inform if they had concerns but in practice did not always make referrals when they were required. Staff said they had raised alerts when needed and these were responded to. However, we observed a multidisciplinary team meeting where staff discussed a young person who had been seen by a community support worker. They had raised concerns about parents shouting at the young person. There was no discussion about working with other agencies to explore this further or to discuss any safeguarding concerns. Staff also discussed some safeguarding concerns about a young adult. These had not been picked up by the staff member who visited the person the previous week. Staff were to raise a safeguarding after the meeting, but the team did not consider the possible risks of staff members going out alone on future visits.

Managers took part in serious case reviews and were making changes based on the outcomes. Following a serious incident, managers told us that safeguarding scenario face to face training was to be delivered to all staff, however, at the time of inspection in June this had not started, and staff were not aware of this.

Staff access to essential information

Staff working for the mental health community teams did not keep detailed records of patients' care and treatment. Records were not clear, not up-to-date and not easily available to all staff providing care.

Patient notes were not comprehensive, although all staff could access them easily. The provider had provided 200 laptops for staff so that they could access records and work remotely when needed.

When patients transferred to a new team, there were delays in staff accessing their records as different services involved in the person's care used different electronic record systems. When we reviewed care records, we found that some files

were corrupted and could not be read. Staff said that when people accessed the emergency department at the general hospital, staff from the hospital would liaise with the community teams. They used a different records system to the general hospital but had a good working relationship with them and would pass information to them and vice versa. The inpatient service at Parkview used paper records.

Records were stored securely, and electronic records were password protected.

Medicines management

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored safely. Staff did not always regularly review the effects of medications on each person's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. We observed that doctors reviewed people's medicines during appointments and spent time discussing with them and their family, where appropriate, their medicines, any side effects and why it was important to take the medicine.

Staff did not always review the effects of each person's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. For example, whilst most records we reviewed contained blood test results, electrocardiogram results and monitoring of their weight and blood pressure. However, for one person their records lacked evidence that they were being appropriately monitored.

Staff did not always store and manage medicines and prescribing documents in line with the provider's policy. Staff checked the temperature of the rooms and fridges where medicines were stored and checked weekly that the medicines in the emergency bags and oxygen were in date. However, we found some medicines and equipment that had expired up to 12 months before our inspection. Whilst out of date medicines and equipment were disposed of, we were not assured of the expiry date processes and out of date medicines and equipment could have been used.

Arrangements were in place so that staff could safely transport medicines to people in the community when needed. However, they said that people usually attended the hubs for medicines such as depot injections.

Track record on safety

The service did not have a good track record on safety.

There had been three serious incidents related to the deaths of young adults using the service since our previous inspection.

One patient under the East team had died and the provider was notified of their death by the coroner. The provider identified that the patient had been 'lost to follow-up' in March 2022 and had made two unsuccessful attempts to contact the patient by telephone. The provider identified some potential gaps in this patient's care which included lack of clarity about whether the patient was discharged from the Hub, or from the care coordinators' caseload. Records were not clear as decisions appeared to have been made about treatment but not implemented, and correspondence did not appear to have been sent as required.

Specialist community mental health services for children and young people

The coroner sent the provider a Prevention of Future Deaths report following another patient's death. The coroner was concerned that information was not adequately conveyed between agencies involved in the patient's care. As a result of this the provider had taken action to improve intra-agency co-operation in attempt to mitigate against the risk of further deaths in the future.

Another death was of a young child of a patient. There were significant concerns about the practice of the service in supporting the patient and that concerns raised by other agencies had not been responded to responsively. The provider was part of a joint multi-agency review which identified urgent learning for them, and we saw that actions were in place to address this.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Managers did not investigate incidents and share lessons learned with the whole team and the wider service. However, staff reported incidents and when things went wrong, staff apologised and gave people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff said they knew how to use the providers electronic incident reporting system and records showed they had reported in line with trust policy. However, managers did not investigate incidents in a timely way. The trust provided information about incidents reported for the last three months up to 28 June 2022. For the community mental health core teams 56 incidents had been recorded. Only one had been reviewed and closed and two were identified as being investigated. 53 of the incidents (95%) were awaiting investigation. In none of the eleven incidents related directly to risks to and from patients (safeguarding, violence and self-harm) was there any indication that actions taken included an update to risk assessments and care plans.

Following our inspection, we requested immediate assurance from the trust with regards incident management. The trust responded and took immediate action to rectify this area of concern.

Managers debriefed and supported staff after any serious incident. Staff said they were debriefed in the team "daily huddle" meeting after serious incidents and supported.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us about learning from incidents and following the deaths of three young people who had used the service they were informed of changes that had been made. For example, changes to communication how the service worked with other agencies involved in people's care. However, we found that not all staff were aware of the trust plan to provide scenario training in safeguarding following a serious incident.

Staff understood the duty of candour. There was evidence they were open and transparent and gave patients and families a full explanation if things went wrong.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Specialist community mental health services for children and young people

Assessment of needs and planning of care

Staff did not fully assess the mental health needs of all patients. They did not work with patients and families and carers to develop individual care plans and update them when needed. Care plans did not always reflect the person's assessed needs and were not always personalised.

Staff did not always complete a comprehensive mental health assessment of each person who used the service. We looked at 17 records of children and young people who used the service. We found that care plans were not always updated when risk assessments were updated due to a change in risk. For example, one young person had a risk assessment dated February 2022 where thoughts of self-harm and suicide were discussed, but this young person did not have a care plan. They were only allocated a care coordinator the week before our inspection.

In the records reviewed for young adults (18-25 years) staff assessed people's mental health and physical health needs. However, they did not develop a comprehensive care plan for each person that met their mental and physical health needs. One person's records indicated that other family members had mental health needs, but this was not included in their care plan. Another person's care plan had not been updated since March 2018, but their records indicated that their needs had changed.

Staff made sure that children and young people had a full physical health assessment and knew about any physical health problems. However, records showed that these assessments did not always inform care plans. For example, one young person's records included correspondence dated August 2021 following a medical review which stated they had suicidal thoughts. There was no risk assessment, care plan or information about their physical healthcare.

Staff did not always develop a care plan for each child or young person that met their mental and physical health needs. Three records we looked at did not contain a care plan.

Staff did not always regularly review and update care plans when the person's needs changed. For example, in one person's record from June 2018 it was stated that they required a review of physical health care monitoring, but the physical health care part of their record was empty. One young person's care plan dated March 2018 had not been updated since, but the person had a diagnosis of depression which was treated with antidepressants. The letter to their GP and medical review from 2020 and 2021 respectively, could not be read due to file download issues so it was not clear if the person had now been seen.

Care plans were not always personalised, holistic and recovery orientated. From the 17 records we looked at we found that five children and young people did not have a care plan. Another care plan did not include how staff were to meet all the assessed needs of the young person. Another care plan had not been updated since October 2020, but the young person's records showed their needs had changed. In four young adult's records reviewed there was not a care plan that showed staff how to meet the patient's needs. However, we saw one care plan that had been developed by the patient and was very personalised.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. However, they did not always ensure that people had good access to physical healthcare. Staff supported people to live healthier lives. Staff used some recognised rating scales to assess and record severity and outcomes. Staff participated in some clinical audits, but these needed to be more robust to ensure people received effective treatment.

Specialist community mental health services for children and young people

Staff provided a range of care and treatment suitable for the people who used the service based on national guidance and best practice. This included Cognitive Behavioural Therapy (CBT), Dialectal Behavioural Therapy (DBT), Eye Movement Desensitisation and Reprocessing (EMDR) therapy and Solution Focussed Therapy (SFT). Staff told us they were soon to deliver Non-Violent Resistance (NVR; a psychological approach for overcoming destructive, aggressive, controlling and risk–taking behaviour) virtually to parents where this was appropriate.

There was one early intervention for psychosis service aligned to each hub so that people could be referred to this service from other teams.

Staff did not always make sure people had support for their physical health needs, either from their GP or community services. For example, one person's records stated they needed their physical health reviewed in June 2018 but there was no evidence this had been done. However, most records showed, and we observed in appointments that staff considered people's physical health needs. They completed physical health observations on people as part of their assessment which included blood tests, electrocardiogram and blood pressure checks.

Staff supported people to live healthier lives by supporting them to take part in programmes or giving advice. We observed staff talking to people in appointments about good sleep hygiene and taking regular exercise.

Staff used some recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes including the SCORE-15 systemic family therapy outcome measure reviewing therapeutic change in family functioning. However, we did not see that Paediatric Early Warning Scores were used to assess children's physical health needs.

Staff took part in some clinical audits. Nursing staff completed weekly clinic and medicines card audits. We found at our inspection that regular audit systems were not in place to identify if risk assessments and care plans were updated as needed and incidents were investigated in a timely manner. Following our inspection, a more robust audit schedule was implemented to identify where there were gaps in patient care and if and what improvements were needed.

Operational managers were working on quality improvement initiatives. These included the 'lost to follow up' work. From the waiting lists managers identified children and young people who were potentially 'lost to follow up'. For some of these people staff had not updated the computer system to say the person had been discharged from the service or what clinical input the person had received. Staff were working through these lists to identify if the person needed further contact and support. Operational managers had also reintroduced improvement huddles and were asking staff to suggest what improvements could be made within the service.

Skilled staff to deliver care

Some teams did not include the full range of specialists required to meet the needs of people who used the service. Managers did not make sure that staff had the range of skills needed to provide high quality care. However, they supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of the people who used the service. There were vacancies across the teams for other staff including therapy staff. In the North team the occupational therapist post had been filled. In the West team there was a vacancy for an advanced practitioner and one psychology post was unfilled whilst a member of staff was on maternity leave. In the South team there were 1.8 whole time equivalent vacancies for psychologists and one psychology assistant. Staff told us that the staff shortages in the West team impacted on the North team. These two teams were both based at Finch Road. Staff said that if there was a need to

support a person using the service but no staff from the West team were available, staff from the North team had to support the person. There were two family therapist vacancies in the East and North teams. In each team there were community support workers. However, people could be referred to staff in other teams to ensure they still received an effective service.

Managers did not ensure staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. Staff working with young people under 18 did not have specialist training in Child and Adolescent Mental Health Services (CAMHS), and only some staff had training in autism or attention deficit hyperactivity disorder (ADHD), for example those considered ADHD specialists. Support workers said they needed training on suicide prevention.

Staff said a lot of their training was eLearning or online and they would benefit from more face-to-face training. Psychotherapists had designed training for staff titled 'A Psychoanalytic Approach Informed by Neuroscience and Child Development Research'. They had delivered this online to staff but were requesting from managers that this be delivered to staff face to face due to the content and the need for more detailed discussion. However, managers told us they encouraged staff to access external training courses, for example nurses could access cognitive behavioural therapy and dialectal behavioural therapy training, non-medical prescriber training and some staff were working towards a degree in working with children and young people.

Doctors within the teams did not work across the age range from 0 to 25 years but were specialist in working with people under 18 or over 18. However, in the East team there were vacancies for two CAMHS consultants.

Managers supported staff through regular, constructive clinical supervision of their work. The provider told us that the average rate of supervision that staff had received from March to May 2022 was 89%. All staff could also access weekly peer supervision where they discussed patients and their care, they said all staff including administrative staff could attend this.

Managers supported staff through regular, constructive appraisals of their work. The rates of appraisal in June 2022 were 77% which was under the key performance indicator of 95%. However, all managers were aware of which staff needed an appraisal and were asked to complete these by end of June 2022.

Managers made sure staff attended regular team meetings however the minutes of these were not always available for staff who could not attend. Staff told us there were regular team catch ups and they worked well as a team however, these catch-up meetings were mostly informal and not recorded for those who could not attend.

Multidisciplinary and interagency teamwork

Staff from different disciplines did not always work together as a team to benefit patients. The teams did not always have effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients. We observed three multidisciplinary team meetings during our inspection. However, in the meeting we observed in the North team, for children and young people under 18, we found there were no clear lines of accountability or ownership of the decisions made. We did however observe in the North multidisciplinary team meeting for people over 18 years the meeting was coordinated and there was action planning with clear lines of accountability as to who was responsible for completing the action.

Staff told us the multidisciplinary approach was disjointed. For example, a person using the service may only be under an occupational therapist or a psychologist and have no care coordinator. The trust explained this was part of their care allocation approach, but staff told us they felt this model lacked clarity around who had responsibility for patient care. Psychologists said that they felt listened to and valued as part of the multidisciplinary team. However, psychotherapists did not feel part of the multidisciplinary team and said their clinical opinion was not valued. For example, psychotherapists told us there had been occasions where a person who had complex needs has not been allocated a core worker because their input has been disregarded.

However, staff said the 'daily huddle' was very useful and staff could share what they were doing and discuss risks to people who used the service.

Staff had effective relationships with other staff within the organisation. However, some processes were disjointed and put additional time pressures on staff. For example, when a person was waiting for an inpatient bed, the bed managers had to contact staff members directly for information pertinent to admission, such as risk assessments and care plans. If the staff member contacted did not see the email, then the child or young person could lose the bed. Staff also had to download the care plan and risk assessments and attach to the email back to the bed manager which staff told us took a long time.

Staff did not always have effective working relationships with external teams and organisations. For example, we saw that concerns were raised about a young person's involvement in County lines drug gangs. We saw this was discussed at the multidisciplinary team meeting, but staff did not follow this concern up with local drug teams. For another young person staff did not know which school they went to so were unable to liaise with school staff. Another person's records did not show there had been any liaison with a team in another area that they had transferred to.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff said their training was up to date and there was information available on the Trust intranet with any updates that affected people who use the service. We did not see the compliance figures for this training.

Staff said they knew how to access support and advice on the Mental Health Act and who the Mental Health Act administrators were.

People who used the service did not always have easy access to information about independent mental health advocacy. At Blakesley (East hub) and Oaklands (South hub) staff said that all information in reception areas had been removed during the Covid-19 pandemic and needed replacing. However, staff said that in appointments they would give people information about advocacy if appropriate.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly. Staff understood what they needed to complete for patients on a Community Treatment Order and where to get advice from the Mental Health Act administrator when needed.

Specialist community mental health services for children and young people

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The multidisciplinary team had agreed that one patient's Community Treatment Order could be ended. We saw that staff had arranged to meet the patient and their relative to explain what this meant for them, their rights and what support they would continue to receive from the team.

Good practice in applying the Mental Capacity Act

Staff did not always support people to make decisions on their care for themselves. They did not always assess and record capacity clearly for people using the service who might have impaired mental capacity. However, staff we spoke with understood the trust policy on the Mental Capacity Act 2005.

Staff did not always receive or were not up to date with training in the Mental Capacity Act. The average for training across the community core teams was 60%. Ten members of staff in the West Team and seven in the South team needed to complete this training. We saw no evidence that staff were booked to attend this training.

Staff we spoke with had a good understanding of at least the five principles and understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary.

Staff were aware that a person may lack capacity when their mental health was relapsing. Staff said they assessed people's capacity to understand information and make specific decisions on all duty calls.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff were aware of how to access information on the Mental Capacity Act on the providers intranet.

Staff told us they gave people all possible support to make specific decisions for themselves before deciding the person did not have the capacity to do so. Information was provided in formats accessible to children, young people and young adults and staff used interpreters where needed.

Records did not always show that staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision. Four of the five records we looked at for people under 18 years at Blakesley (East hub) did not contain any evidence that staff had assessed or recorded the person's capacity to consent.

In an appointment we observed for a young adult, the patient's relative had the appointment with their doctor in their absence and personal information was shared. There was no evidence during the appointment or in their records that the patient had consented to this or an assessment of their capacity to make this decision.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Specialist community mental health services for children and young people

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. However, they did not always understand the individual needs of patients and support them to understand and manage their care, treatment or condition. Some people did not feel that staff listened to them.

During this inspection we spoke with 10 people who used the service and 18 of their carers or family members. We observed and most children and young people who used the service and their relatives told us that staff were discreet, respectful, and responsive when caring for them. However, two people told us they did not feel listened to by staff.

We observed in appointments that staff supported people to understand and manage their own care treatment or condition. We observed a doctor speaking to a young person in a respectful way, they took time to explain to them about their condition, listened to them and spoke in a soft tone to help relieve their anxiety. Another doctor we observed spoke with the young person about what they liked doing, their interests and hobbies and listened to their responses. However, **d**uring our inspection we observed a staff member speak about a concerned parent of a young adult in a derogatory way that showed they did not understand the patient's individual needs or the relative's frustration and distress. We escalated this to managers at time of inspection who responded appropriately and managed this.

People who used the service and their families said staff were caring, helpful, treated them well and behaved kindly. However, people told us that access into the service and allocation of a care coordinator often took too long which had been very difficult.

Staff directed people to other services and supported them to access those services if they needed help. People were signposted to Pause drop-in service which they told us helped them. (Pause is a drop-in service run by the Children's Society on behalf of the trust where people can find out more about mental health and attend groups and courses.) People told us that when in crisis staff told them to go to the local A&E department which was not always very helpful as staff there did not always understand their needs. The trust explained patients would only be directed to attend A&E if this was the safest course of action.

Staff followed the trust policy to keep information about people who used the service confidential. People's electronic records were password protected. Staff were aware of when and where to use laptops when out visiting people who used the service in the community.

Involvement in care

Staff did not always involve people who used the service in care planning and risk assessment. Staff did not always inform and involve families and carers appropriately. However, they ensured that people who used the service had easy access to independent advocates.

Involvement of patients

Staff said they involved people who used the service in their care plan, but some people said they did not have a copy of their care plan. Three people said they had not seen their care plan and did not know if they had one. In one appointment we observed the person's care plan was not reviewed.

Staff said they helped make sure people who used the service understood their care and treatment (and found ways to communicate with people who had communication difficulties). Staff said they used interpreters when needed. However, one relative said staff did not talk to their child at a level that they understood.

Specialist community mental health services for children and young people

People who used the service could give feedback on the service and their treatment and staff supported them to do this. Staff involved children and young people who used the service in decisions about the service, when appropriate. The trust has a youth advisory group called 'Think 4 Brum' that gave children and young people who used their services an opportunity to shape the design and delivery of the service. People were also involved in staff interviews and had helped to produce a video for staff suicide prevention training. People and their families told us that the trust was committed to co-production work, and they felt able to input.

Staff made sure children and young people could access advocacy services. They had links to Barnardo's workers who provided the independent advocacy service.

Involvement of families and carers

Staff did not always support, inform and involve families or carers. For example, two relatives said they did not feel listened to and had to fight to get a service. One said they felt that staff did not respect their view and undermined their opinion. However, we observed a doctor asking for the parents' opinion and involving them in decisions about medicines to prescribe and any side effects these may have on their child. Another relative of a young adult told us that they had not seen the psychiatrist face to face which they had requested but appointments were always by telephone. We observed during the telephone call that at times this made it difficult for the relative and the person to understand all the information given to them. However, other relatives told us they were involved and felt listened to. One relative said, "We are involved with the care plan and staff meet my relative at college, which is great." We observed another telephone call where the young adult's family were involved, staff engaged well with the person and their relative and listened to their views.

Relatives said the care coordinators made a massive difference and without them they would be broken. They said the care coordinators were consistently great. One relative said, "Without Forward Thinking I would be lost".

Staff gave carers information on how to find the carer's assessment. This was part of the CHOICE assessment. (A CHOICE assessment is an initial meeting where a CAMHS professional will talk to the child or young person who is unwell, listen to their symptoms and decide how to help them.) Staff said carers were invited to reviews where any needs were identified, and they referred carers to social services if support needs were identified.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate.

Access and waiting times

The service was not easy to access. Staff did not always assess and treat people who required urgent care promptly and people who did not require urgent care waited too long to start treatment. Staff did not always follow up people who missed appointments.

The service did not always ensure that people, who would benefit from care from another agency, made a smooth transition. This included transitions to adult mental health services which sometimes meant there was disruption to the patient's care.

Specialist community mental health services for children and young people

The service did not have clear criteria to describe which people they would offer services to and if they were to offer people a place on waiting lists. People who used the service and their relatives told us they did not know what services they would be referred to or if they were on a waiting list.

People and their families could self-refer, or their GP or other health professional could make a referral on their behalf through a central city-wide Referral Management Centre (RMC). Parents we spoke with told us the service was not easy to access and the records we looked at reflected this. For example, one child waited five months for a CHOICE assessment. Another child waited four weeks for their referral to be accepted, waited nine weeks to be allocated to a team member and were awaiting a CHOICE assessment at the time of our inspection over three weeks later. Another child waited 12 weeks to be allocated to a team member which was four months after their CHOICE assessment and there was no plan as to what intervention or treatment they needed. People and their families told us they had to wait from six months to two years for an initial appointment and this sometimes led to them needing urgent care as they were in a crisis. One young person told us they had been referred by their GP, but they did not know if they were on the waiting list. It was not clear how people were prioritised as needing urgent care or treatment.

The service did not meet trust target times for seeing patients from referral to assessment and assessment to treatment. Managers told us that during the COVID –19 pandemic the number of referrals to the service had increased significantly which had put pressure on their ability to see people in a timely manner and to reduce the waiting times. They said that before the pandemic there were an average of 30 – 40 referrals per month. However, in the month before our inspection there were 140 referrals which meant that they could not meet their 18-week trust target from referral to treatment. They had a COVID-19 recovery plan which included staff recruitment and retention to help address the increased referrals.

To mitigate risks associated with waiting times, staff referred people to external organisations for therapies whilst they were waiting for a service. For example, referrals were made to Living Well Consortium (counselling service) and people could also attend the Pause clinic. There was also a STICK (Screening, Training, Intervention, Consultation, Knowledge) teams whose staff were employed by the trust and worked with children and young people in schools and colleges.

The trust had employed agency psychologists to reduce the psychology waiting lists. At the time of our inspection for young adults (18-25 years) these had reduced from 60 patients waiting to 20 patients in two months.

Staff did not always contact people who did not attend appointments to offer support. A relative of a patient telephoned the community team because their relative had run out of their prescribed medicine. They were told they had an appointment the week before but did not attend. This was because they had not received a letter informing them of the appointment. This meant that staff had not followed the trust policy that stated, “For new referrals where there are risks identified inform the GP/Referrer/other involved agencies that the patient did not attend as soon as possible; within a maximum of 24 hours on a weekday or 72 hours at weekends (Friday pm or Monday am).” Their records showed risks were identified but no contact had been made when they did not attend their appointment.

The service used systems to help them monitor waiting lists. Each patient was risk assessed and reviewed dependent on their level of identified risk whilst on a waiting list for treatment.

Doctors told us they assessed people’s needs and made decisions around discharge as a multidisciplinary team. However, the trust had identified that some people who used the service had been ‘lost to follow up’ and decisions had not been made whether to discharge them or not. There was a death of a young person in April 2022 who had been identified as ‘lost to follow up’.

Specialist community mental health services for children and young people

People told us they did not always have flexibility and choice in the appointment times available or choice of a face to face or telephone or video appointment. People said they had requested face to face appointments, but these had not been offered. One person's records stated a face-to-face appointment was needed but we observed their appointment to be by telephone. The person and their relative did not always understand what the doctor said to them and the treatment options available.

People did not always feel supported when they were referred or transferred between services. Staff were alerted when a patient was 24 years and six months that they needed to transfer their care to the local adult mental health trust. Staff said there were sometimes delays in transition and one patient's records showed they were over 25 years old. Staff told us that the local adult mental health trust policy was not to accept patients who were an inpatient to the adult community mental health team. This had resulted in a person who was 26 years old being transferred to a Forward-Thinking Birmingham community mental health team and then transferred to an adult team. This affected their journey through services as it was disjointed, and they were moved around teams. We observed a telephone appointment with another patient who was nearly 25 years of age and their relative. The doctor was unclear about who the next community team would be as their referral had not yet been accepted. The patient and their relative said this had been an anxious time for them and they did not feel supported in the transition process. Managers told us there were 50 patients from the East hub that were delayed transfer of care to other services including the adult mental health trust. They had a referral form to the adult mental health trust and monthly meetings with them to discuss referrals and their progress. The trust told us they would maintain responsibility for patients despite their age until a full transfer of care could be successfully completed.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment but not always their privacy and dignity.

The services had a full range of rooms at two of the hubs Oaklands (South) and Blakesley (East) to support treatment and care. However, at Finch Road (North and West) staff said there were difficulties with booking rooms for face-to-face therapy sessions and there were not enough large rooms to accommodate families for family therapy sessions.

Interview rooms at Oaklands did not have sound proofing to protect privacy and confidentiality. We overheard a child having a therapy session during a walk around of the building due to lack of sound proofing. The trust had plans for sound proofing refurbishment to take place but this had not commenced at the time of inspection.

At Blakesley there were two rooms with white boards at a low level so young children could access them. At Oaklands there were therapy rooms with white boards that covered the walls so the person could write or draw over them in their sessions. The therapy rooms did not have anything else in them and therapists said this was so the person did not link the room with any experiences elsewhere and had a blank space in which to have their treatment. The psychotherapists said this was important for people's therapy.

At Oaklands in the reception area there were no leaflets, books or toys or user-friendly information for children and young people. The trust explained this was due to infection prevention control restrictions in place.

Meeting the needs of all people who use the service

The service did not meet the needs of all people who used the service as two of the hubs could not easily accommodate people who had a physical disability. Staff did not always have the resources available to help people who used the service with communication, advocacy and cultural and spiritual support.

Specialist community mental health services for children and young people

The service could not support and make adjustments for people with a physical disability at Oaklands and Blakesley hubs. At Oaklands there were no accessible toilet facilities and only one clinical room could accommodate a person with a physical disability. There was a ramp from the car park, but reception staff would need to open the door to access the clinic room. The trust had recognised this as a risk and were looking at alternative accommodation. There was no ramped access to the front entrance at Blakesley, the corridors were narrow and there was not a lift, but there was an accessible toilet. The trust was planning to relocate Blakesley to a health centre which was fully accessible, and this process was under consultation at the time of our inspection.

Records showed that a person who used the service had asked for a female therapist, and this was accommodated. We observed another appointment where the doctor asked open questions about the young person's personal relationships. However, some people told us that their protected characteristics were not always considered. For example, an assumption was made about one young person's sexual orientation during an appointment, without the young person being asked.

Staff did not always make sure patients could access information on treatment and local services. The service had information leaflets available in languages spoken by the patients and local community at Finch Road, but these were not available at Blakesley or Oaklands as staff said they had been removed during the COVID-19 pandemic and needed replacing.

We observed during a patient's appointment by telephone with the doctor that the doctor mentioned a different diagnosis but did not provide information about this. Their parent told us they would have to look online for information as they knew nothing about this diagnosis.

Managers made sure staff and patients could get hold of interpreters or signers when needed. However, in an incident that occurred prior to our inspection staff had not used the interpreting service to talk with a person who used the service.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, however some people did not know how to complain, and it was not always clear how they were investigated.

People who used the service, their relatives and carers did not always know how to complain or raise concerns. Half of the people who used the service and family members we spoke with did not know how to make a complaint and were not confident that it would be responded to if they did. One person's record included a formal complaint raised by their parent about coming to an appointment but due to staffing was not able to be seen and then waited too long to be seen again. There was no evidence that the provider had discussed this complaint with the parent or sought to resolve it. Information about how to make a complaint was not available in the hubs as leaflets had been removed during the COVID-19 pandemic and not yet replaced.

Staff understood the policy on complaints and knew how to handle them. Staff told us they were aware of the complaints process and when on duty said they often dealt with complaints and handled them appropriately.

Staff knew how to acknowledge complaints but people who used the service told us they did not always receive feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers told us they shared feedback from complaints with staff in 'daily huddles', team meetings and via email and newsletters.

Specialist community mental health services for children and young people

Is the service well-led?

Inadequate 

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders did not always have the skills, knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed, and some staff said they were not visible in the service.

Leaders had not effectively identified areas of concern identified on inspection as described throughout the report. Leaders had not put effective measures in place to ensure the safety of patients.

At Oaklands there had been four different team managers although a new operations manager had been in post since April 2022 and staff reported the team was now more settled. Some staff told us that they did not usually see senior managers in the hubs, but they were there just for our inspection.

Staff told us that the trust provided leadership training for staff who were band 6 and 7 and they had benefitted from this training.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff were aware of the trust values of Ambitious, Brave and Compassionate and these were displayed in the community hubs. Staff said they received regular communication via emails about these.

Culture

The majority of staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff across the community hubs said that staff morale was low mainly due to staffing issues. However, they knew that managers were trying to recruit staff, but retention of staff needed to be managed more effectively.

Some staff told us they felt supported and there was good team working. They said they could raise concerns without fear of being discriminated against and were aware of the trust Freedom to Speak Up process. Staff said they could give feedback in meetings and there was an annual staff questionnaire.

Administration staff said they were unsupported by managers and generally did not see managers in the community hubs.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

Specialist community mental health services for children and young people

We found that a robust audit system was not in place that assessed risks within the teams and identified how these could be safely managed. For example, managers had identified several people who used the service who were 'lost to follow up' and were working to address this. However, from the records we looked at and people we spoke with we identified further people who had not had an appointment or did not attend appointments suggesting the system used to identify those 'lost to follow up' was not effective.. We also found that risk assessments had not been completed, were not detailed or not reviewed. We also found several incidents reported on the electronic incident reporting system had not been investigated or any action taken in a timely manner to ensure people were not at risk of harm.

Following our inspection, we requested immediate assurance from the trust that improvements be made to risk assessments and incident management The trust responded to this and put in place daily task and finish groups to address the lack of governance systems, and weekly reports were sent to a meeting chaired by the Chief Executive Officer. The trust also put in place daily 'touchpoint' meetings in the community teams to ensure that staff were aware of risks of and to people who use the service and how to manage these. They also put in place visual reminders for staff to complete risk assessments on computer screen savers and notices displayed in the community hubs. They requested their external auditors to do a review of their governance systems to ensure the changes they have made have been embedded and risks to people who use the service were reduced. However, we revisited the service between 10 and 11 October 2022 to review progress against this plan and found that whilst some improvements had been made, such as with regards review and management of incidents, there remained concerns about staff abilities to use the current patient electronic recording system to record and access patient risk assessment and management plans.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care so they could not use that information to good effect.

Managers told us the main risks to the service were workforce and staff recruitment and retention, and they were working to improve recruitment across the teams, including conducting recruitment campaigns in other countries. These items were included on the trust risk register. However, the findings of this inspection showed that although managers had identified workforce and staffing as a risk and were doing work on people identified as 'lost to follow up' they had not identified the risks of lack of risk assessment and risk management. Audit processes that managers used had not identified the risks in the service and these were not being managed effectively.

Operation managers told us they had access to the information they needed. However, systems were not operating effectively to identify all those 'lost to follow up', and we found that people had missed appointments because they did not receive notice of these in time due to system issues. Therefore, from our inspection we found that teams did not always have the information they needed to manage risks and provide safe and effective care.

Information management

Staff collected some analysed data about outcomes and performance, but some information was not available to them. Staff were starting to engage actively in local quality improvement activities.

Staff could access a weekly report of people who used the service who had been identified as 'lost to follow up' and were working through this information to make contact and address the reasons why and what service they needed to offer. Managers had identified one of the reasons for this could be turnover of doctors who had not completed on the electronic records system the outcome of the appointment and were addressing this.

Managers were working on reducing waiting lists and could now access a report on this to ensure they were being managed. They said the system had been updated since our previous inspection so staff could manage the numbers waiting and risks to them. However, the findings of our inspection were that some people on the waiting list had no contact from the teams so there was no evidence that their risks were being assessed.

The trust had provided 200 laptops to staff to ensure they had easy access to the information they needed and could work remotely from the hubs when needed.

Engagement

Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) but this was not always effective to ensure that there was an integrated local system that met the needs of people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

The trust worked with the local adult mental health trust and had joined in partnership with them to provide an all-age urgent care centre. However, due to staffing challenges the trust was not able to provide staffing to the health-based place of safety for people under 18 years. Children and young people were referred to the local accident and emergency department if they were in crisis but told us that staff there did not always have the expertise to support them, and staff in the service felt this arrangement put pressure on the local hospitals.

The trust had a team – STICK (Screening, Training, Intervention, Consultation, Knowledge) that worked within schools to support children and young people. They worked with the Children's Society to provide the Pause centre in Digbeth where people could get help and advice and access to counselling services. They worked with the Living Well Consortium and referred people to them for counselling services.

We found that the trust did not always work well with the local adult mental health trust to ensure that patients had a smooth transition to the adult service when they were 25 years old. Staff told us that they referred people at 241/2 years of age, but the adult mental health trust did not always accept referrals which caused a delay in transfer of people's care.

Learning, continuous improvement and innovation

Managers told us about a new digital patient communications portal that was being implemented across the trust during 2022 called Dr Doctor. The aim of the portal would be to allow staff to deliver messages to several children and young people who use the service at one time and to provide a two-way text messaging service to receive responses back**.** The portal was being piloted across the trust during June. The portal will also integrate with the trust electronic patient record system and will provide an alert to staff if the patient does not access the portal for five days and send out a letter to make contact. Managers hope the portal will reduce the risk of patients being 'lost to follow up'. The portal will also be linked to a video conferencing facility which will provide an option to be seen by video link. Managers told us they were aware of digital poverty risks and said they would ensure that these risks are reduced for patients unable to access the portal.

At the Blakesley (East) hub operations staff had started a newsletter for staff to share ideas, news and what has been done as a result of staff feedback. The newsletter provided information about admin and Information Technology support, furniture for clinical rooms, trust self-defence classes, and encouraged staff to ask patients to complete a survey to gain an insight into their experience.

Specialist community mental health services for children and young people

At Blakesley staff had relaunched improvement huddles fortnightly and saw this as a way of engaging with staff to make improvements needed to benefit them and the people who used the service. However, on the improvement whiteboard the only thing identified as needed improving was that the fridge was broken, and this had been repaired. Considering our findings from this inspection it is concerning that staff had not identified any of the improvements needed that we found.

Birmingham Children's Hospital

Steelhouse Lane
Birmingham
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Tel: 01213339999
www.bch.org.uk

Description of this hospital

The Birmingham Children's Hospital is over 150 years old; services have been provided from Steelhouse Lane since 1862. Birmingham Children's Hospital is a specialist paediatric centre with 378 beds, including a dedicated 31 bed paediatric intensive care unit, offering care to young patients up to the age of 16 from Birmingham, the West Midlands and beyond. Forward Thinking Birmingham community mental health service provides services for 0-25 year olds.

The service has a national liver and small bowel transplant centre and are a global centre of excellence for complex heart conditions, the treatment of burns, cancer and liver and kidney disease. They are a nationally designated specialist centre for epilepsy surgery and have a paediatric major trauma centre for the West Midlands.

They have one of the largest Child and Adolescent Mental Health Services in the country, with a dedicated inpatient Eating Disorder Unit and Acute Assessment Unit for regional referrals of children and young people.

Critical care

Outstanding ☆ ➔➔

Is the service safe?

Outstanding ☆ ➔➔

Our rating of safe stayed the same. We rated it as outstanding.

Mandatory training

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

All staff received and kept up to date with their mandatory training. The trust had a comprehensive mandatory training programme. which included modules on conflict resolution, equality, dignity and diversity, infection control, risk, health and safety, mental health and newborn bloodspot. The trust target was 95%, all staff had achieved compliance rates at or around the target with many modules in excess of 95%.

Staff received annual training on sepsis management, including the use of sepsis screening tools and use of sepsis care bundles. Sepsis management was included in the 'Observation, Monitoring and Escalation Policy'.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and autism as part of their mandatory training and some went on to complete further training where they felt less confident. The service had a nominated education lead consultant and lead nurse who took responsibility for the organisation and delivery of training for critical care staff with the clinical education team.

The education team monitored mandatory training and alerted staff when they needed to update their training. We reviewed training compliance data for completion of the critical care specialist course. All staff in bands 6 to 8a (104 staff) had completed the course with the shortfall in band 5 staff (26/192 staff). This was due to the loss of two cohorts during the COVID pandemic, however they were all due to complete this in either September 2022 or January 2023. Staff rotas showed, there was always a band 6 or band 7 nurse on every shift.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance data showed all staff had received training appropriate to their role. This included Safeguarding Adults Level 1 (99%), Safeguarding Children Level 1 (100%), Safeguarding Children Level 2 (98%) and Safeguarding Children Level 3 (98%).

Staff we spoke with told us how they would identify adults and children at risk of, or suffering, significant harm and how they worked with other agencies to protect children, young people and their families.

A 'Safeguarding Children' policy was in place. The policy aimed to ensure that regardless of age, gender, religion or beliefs, ethnicity, disability, sexual orientation or socioeconomic background, all children had a positive and enjoyable experience at the trust in a safe, child centred environment and were protected from abuse whilst under the care of the trust. In addition, the policy signposted staff to regional safeguarding guidance on specific areas of concern including child sexual exploitation, domestic abuse, female genital mutilation, neglect and children with disabilities.

Safeguarding posters were on display and staff knew where to find the trust's safeguarding policies and procedures which were located on the intranet. Staff knew how to contact safeguarding staff and safeguarding supervision was available to staff to ensure the staffs' learning and support needs were met by staff who specialised in safeguarding children.

The trust had a safeguarding team who provided advice and support to all staff, working with colleagues from social care, the police and education, to ensure children, young people and families were safe and supported to achieve the best outcomes.

All staff we spoke with said the safeguarding team were very supportive and accessible and would take ownership of the case as soon as they were aware to ensure that clinical staff were not taken away from caring for patients. Staff said this was really beneficial as it not only helped them to focus on their patient, but it also helped to separate the safeguarding issues and maintain relationships with patients and families.

Designated child protection professionals were available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there were child protection concerns.

Staff fully engaged in multi-agency working, including appropriate information sharing to effectively safeguard children and young people. This included a system for recognising children who were subject to a Child Protection Plan or in the care of the Local Authority via the national Child Protection Information Sharing System (CP-IS).

Cleanliness, infection control and hygiene

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

The unit was clean and had suitable furnishings which were clean and well-maintained. The service performed well for cleanliness and had a housekeeping team with a housekeeping supervisor dedicated to the unit. We saw team members were very attentive, continually checking that items were clean and properly maintained. We saw a trolley being pushed by a member of staff and a wheel was making a noise. A member of the housekeeping team went straight to check and cleaned the wheel to resolve. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly as we saw during the inspection. Cleaning audit data we saw during the inspection was at or around 100% for each month.

Staff followed infection control principles including the use of personal protective equipment (PPE). Handwashing facilities were located throughout the department and designated hand washing basins that were not for any other use. We observed a range of staff including nurses, doctors and allied health professionals follow best practice for PPE and being 'bare below the elbows' when delivering care. At the time of our inspection, new guidelines had just been introduced regarding infection prevention and control so staff were no longer required to wear masks but those who chose to, could.

Critical care

Monthly audits were completed to assess staff compliance with infection prevention and control standards and guidance. These audits covered topics that included hand hygiene, urinary catheter insertion and ongoing care, CVL ongoing care (central venous line), training and environmental cleanliness. Where concerns had been raised through audits, action plans were in place to ensure the concerns were addressed in a timely manner.

Trust data showed that from January 2022 to March 2022 the average staff compliance rate with hand hygiene across Paediatric Intensive Care Unit (PICU)/Cardiac Intensive Care Unit (CICU) was 87%, however the highest was 90% in March. The actions that were implemented as a result were reminders in handovers, regular auditing and staff reminders as well as education with new foundation groups to address any gaps in compliance.

Actions that were implemented as a result of low hand hygiene audit results had proved successful with an improvement in results for June (98.2%) and July (100%).

The data provided by the trust also showed for the same period that PICU had a compliance rate of 100% for urinary catheter insertion, however lower at an average of 92% for urinary catheter ongoing care. It was documented that reminders were given to staff to complete ongoing paperwork and positive discussions to ensure early removal.

The unit had an isolation room available in C side if required to manage the risks of transmittable infections in line with best practice. We saw that the reconfiguration of the unit meant that this also helped to mitigate any cross contamination as areas could be segregated as appropriate.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw green 'I am clean' stickers around the unit where equipment was ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The design of the environment was in line with Paediatric Intensive Care Society Standards 2008 (PICSS) standards. The service had taken the decision to separate cardiac patients into their own area to give better oversight and ownership of those patients. This meant that the unit had a cardiac intensive care and general paediatric intensive care on the same ward, however appropriate staffing was dedicated to each area.

The service had suitable facilities to meet the needs of patients' families. The paediatric intensive care unit had been recently reconfigured to better meet those needs. There were three areas, A side, B side and C side which were known as kingdoms and patients were cohorted to the appropriate area for their needs. The spacious environment allowed sufficient space at the bedside for the clinical team and families without interfering with the privacy and dignity of patients.

All wards and units were clearly signposted from main corridors.

The unit was locked to ensure the safety of the children and young people. People could only enter the unit by staff within the ward screening them to ensure they were appropriately accessing inpatient areas. Children, young people and their visitors could leave the ward as required/if appropriate by using the exit button or by asking staff to open the doors on their behalf.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation trolleys and found they were sealed and all items in date. We saw that checklists were maintained and told that the housekeeping team were responsible for keeping the equipment clean. We checked 10 items of equipment for service dates, which were all compliant.

The service had enough suitable equipment to help them to safely care for patients and staff disposed of clinical waste safely.

All equipment was stored appropriately and the clinical areas were free from clutter. Staff carried out daily safety checks of specialist equipment. We checked 10 items of equipment around the unit, and saw they were tested regularly to ensure their safety and effectiveness. All items we checked in various trolleys were in date and sealed. The unit had a large number of various emergency trolleys for ease of access and were mirrored on each area.

The tech team took responsibility for service, maintenance and stocking of equipment, which worked well and meant that up to date records were maintained.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any changes. The service used an admission document which assessed all areas of patient care. This document was used trust wide; it was regularly updated with further risk assessments and information and it stayed with the patient throughout their admission.

We looked at five care plans which were all personalised with the patient's name and their likes and dislikes. Care plans were kept by the patients' bedside so that all staff had easy access. Care plans contained a lot of information relevant to the patient and staff said they were updated weekly or sooner if there were any significant changes to their care plan.

Staff completed physiological observations in line with a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff could access patient notes quickly in case any change to their medical condition occurred. Nursing staff provided immediate care for deteriorating patients and requested urgent support from a band 7 or immediate input from a doctor. Staff told us that there was always someone senior around for to support them. Staff continuously monitored the vital signs of patients.

Due to the complex conditions of the children being treated in critical care there was often other factors which could affect the score. For example, patients who required cardiorespiratory monitoring were connected to the monitor at all times. Assessment of the patient included a review of the results displayed on the screen alongside the assessment of the patient's vital signs.

A sepsis care bundle was used for the management of patients with presumed/confirmed sepsis. The Paediatric Sepsis 6 tool was devised in PICU in conjunction with the Sepsis Trust. The tool was based on the adult sepsis 6 tool and informed by expert opinion. Launched in PICU in 2013, the tool had subsequently been endorsed by the Sepsis Trust and implemented in other centres across the NHS.

Critical care

We saw evidence of the use of the Paediatric Sepsis 6 tool for the management of patients with presumed/confirmed sepsis. Treatment was delivered to patients with presumed sepsis within recommended timeframes such as administering antibiotics within one hour. The service had escalation policies for patients who required immediate review, however the team worked so closely together and with patients that all treatment was timely and under constant review.

Arrangements were in place for transfer if a child required urgent critical care at another trust or because they were well enough to be transferred to a hospital closer to home.

The Kids Intensive Care and Decision Support and Neonatal Transfer Service (KIDS/NTS) was a regional transport and advice service, hosted by the trust, dedicated to the management of critically ill infants and children in the West Midlands. Teams of specially trained doctors, advanced practitioners and nurses were available 24 hours a day to transport babies and children to intensive care, paediatric and neonatal units or other ward areas. Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, medical emergencies or behaviour that challenged. Staff were able to seek support from the outreach team.

The outreach team was available 24 hours a day, seven days a week. service. The team brought the required level of care to the patient, assessed and commenced treatment, at ward level, or escalated to critical care if required. They reported directly to one of the PICU consultants in working hours and the senior registrar out of hours. The team aimed to identify patient deterioration early and avoid admissions to the intensive care or high dependency units (HDU) if they were able to implement appropriate interventions at ward level.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff had good access to advice from mental health professionals (Children and Adolescent Mental Health Services team (CAMHS) and could contact the resident mental health nurse who was based in the children's emergency department. Staff said that it was very rare that they would need to seek the support of a mental health professional due to the nature of the patients that they treated. However, the high dependency unit had occasions when they had to seek support and said it was very accessible and timely.

There was a proactive approach to anticipating and managing risks to children and young people which was embedded and was recognised as the responsibility of all staff. Staff shared key information to keep patients safe when handing over their care to others. We observed handovers which were thorough and took a multi-disciplinary approach, which were nurse led. This meant that the information was shared from the staff member who knew the patient best and had nursed them one to one, this gave good ownership and care plans were agreed as a team.

Shift changes and handovers included all necessary key information to keep patients safe. The nurses and medical staff used handover tools to ensure information is clearly passed from shift to shift. The ward round process was clearly combined medical and nursing shared round where they used an in-house developed ward round tool. This covered all areas of patient care, the plans for the day and agreed between the medical and nursing team.

Nurse staffing

The service had enough nursing and support staff, including allied health professionals, with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Critical care

The service had enough nursing and support staff to keep patients safe.Nursing and non-registered health care staffing levels were appropriate for the number and acuity of children normally cared for by the service and the configuration of the unit. An escalation policy showed how staffing levels would respond to fluctuations in the number and dependency of patients. The nurse staffing levels were achieved in line with Paediatric Intensive Care Society Standards 2008 (PICSS), staff were registered children's nurses, there was always a supernumerary shift leader and a supernumerary nurse was available for every eight to ten beds for children requiring level 3 care.

The number of nurses and healthcare assistants matched the planned numbers. We reviewed PICU staffing rotas between 6 July and 31 July 2022, which confirmed that they were staffed in line with PICSS standards. This included ensuring there was a minimum of one nurse per shift trained in APLS/EPLS (advanced or European paediatric life support).

The service had very low rates of bank and agency nurses. The service employed a total of around 400 staff for critical care and very rarely required the support of bank or agency staff. Where they did, managers requested staff familiar with the service and ensured they had a full induction and understanding of the service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager adjusted staffing levels daily according to the needs of patients.

The service had low vacancy rates and regularly recruited successfully. The service had reducing turnover rates. They had done a lot of work around retention of staff, however due to the intense nature of the speciality, staff acknowledged they were susceptible to burnout. The service had implemented measures to protect staff wellbeing and ensured staff had their breaks on time as much as possible. All staff we spoke with said they were proud to work within critical care and felt that their wellbeing was supported over and above expectation.

The service had low sickness rates; however, the highest proportion of sickness was due to stress or musculoskeletal issues.

Additional staff including pharmacy and allied health professionals were readily available to ensure patients received safe care and treatment at all times.

The service had qualified staff to provide support for play, mental stimulation and distraction during procedures, a discharge coordinator was responsible for managing the discharge of children with complex care needs, a pharmacist and physiotherapist both with competences in paediatric critical care were allocated to work on the unit five days a week. On-call access to pharmacy and physiotherapy services was available 24 hours a day, seven days a week.

An education team was available for the training, education and continuing professional development of staff including unregistered staff.

Medical staffing

The service had enough medical staff to keep patients safe.

The service had consultants who were able to attend the hospital within 30 minutes and did not have responsibilities on other sites in order for them to be available 24 hours a day, seven days a week. When on duty for critical care, consultants did not have clinical responsibilities elsewhere.

Critical care

All consultants had up to date advanced paediatric resuscitation and life support competences and undertook continuing professional development relevant to their work with critically ill and critically injured children. All consultants had completed relevant training in paediatric intensive care medicine as described by the Paediatric Intensive Care Medicine Specialty Advisory Committee.

A middle grade clinician was immediately available at all times with competencies including advanced paediatric resuscitation and life support, assessment of the ill child and recognition of serious illness and injury and initiation of appropriate immediate treatment.

We saw from staffing rotas that medical staffing largely matched the planned number. The service had low vacancy rates and reducing turnover rates for medical staff. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Managers could access locums when they needed additional medical staff and managers made sure locums had a full induction to the service before they started work.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We reviewed 12 sets of patient records. We found that they were well organised, clearly documented and signed and showed clear indicators where medication had been given. They included a clear understanding of care plans, appropriate risk assessments and consent. Records contained a contemporaneous account of the care and treatment each child and young person received. This included detailed summaries of communication between staff and parents.

Patient records were stored by the patient bedside, this meant information needed to deliver safe care and treatment was available to staff in a timely and accessible way and included access to test and imaging results, care and risk assessments, care plans and case notes.

We saw staff used a formal handover document as well and verbal handover for people being stepped down from PICU to HDU or onto a ward.

All records were in a paper format at the time of the inspection, however the trust were due to implement electronic records as their long term plan. When children and young people transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed all medicines and prescribing documents safely. Controlled Drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, administered and recorded following local and national guidance. The service had an electronic key system for access to controlled drugs and all other medicines and prescribing documents were stored safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date. We reviewed 12 prescription charts during our inspection, which were all complete and documented clearly and appropriately. Medicines administration records (MARs) contained children and young peoples' weights and allergies to mitigate the risk of unsafe doses and exposure to allergens.

Pharmacy support was provided to ensure regular reviews of children and young people's medicines occurred and they also provided specific advice to the staff, children, young people and their families about their medicines.

The unit carried out regular medicines audits which included storage, management, access, admin and disposal. We reviewed the most recent audit dated 7 April 2022, which showed they were compliant in all areas.

Staff learned from safety alerts and incidents to improve practice. Staff told us they identified a higher than usual proportion of medication incidents for one month. This was flagged following investigation, to the quality improvement lead for changes to be made. Staff were given the opportunity to join the quality improvement project and work as a team to create a new way of working to mitigate the risks identified.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

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

Staff knew what incidents to report and how to report them. We spoke with 26 staff who all told us of a good reporting culture and how incident investigations were used to drive improvements. Staff told us there was a 'no blame' culture at the service which meant all reportable incidents were reported in line with national reporting requirements and trust policy which included StEIS reporting (NHS England's web-based serious incident management system known as Strategic Executive Information System).

Incidents were investigated in a timely manner and children, young people and their families were encouraged to be involved in this process. Lessons learned were identified and shared within the service and trust to reduce the risk of similar incidents from occurring. We reviewed root cause analysis/incident investigations relating to serious incidents that had occurred within the unit. These detailed the causes of incidents and the actions required to prevent further incidents from occurring.

De-briefs were facilitated by senior clinicians and managers following serious incidents to ensure staff were supported through the incident management process. All staff we spoke with praised peers and leads of the service for overwhelming support at difficult times. This was following serious incidents but also when staff were struggling with any aspect of their lives. Service leads said that they valued their staff and felt that their entire wellbeing affected their wellbeing at work and vice versa, therefore they were mindful to offer support personalised to the individual. Staff told us they looked out for one another and service leads were proactive in identifying when staff or families may require some additional support.

Critical care

Managers shared learning with their staff about never events that happened elsewhere and used learning from incidents across the trust to ensure that their service was in line with others. The information was disseminated to division leads and in newsletters and then down to staff huddles and quality improvement meetings. This also included the sharing of national patient safety alerts that had resulted from incidents from other external sources.

Staff understood the duty of candour (DoC). The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that patient. Incident reports recorded when the DoC procedure was required/had been followed. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

The staff worked as a team and made decisions as a multi disciplinary team regarding who was responsible for contacting patients or families. Once that member of staff was identified, they took ownership and carried out the duty of candour. Staff told us when there had been a significant incident on the ward, they had not only spoken to the family involved but had spoken to every other family on the unit, in the spirit of being open and honest, to give those families assurances.

The service had very few incidents, however we did review available incident reports and found they were investigated appropriately and in accordance with the trust's policy.

Staff received feedback from investigation of incidents, both internal and external to the service. We were told that staff were involved in incident investigations and given timely feedback from leaders. Where gaps in learning were identified, staff were provided with bespoke training and could work supernumerary for a time whilst they regained their confidence.

Innovation was encouraged to achieve sustained improvements in safety and continual reductions in harm. The service had a number of innovative practices for their commitment to learning and improvement of services. Learning from Excellence (LFE) was devised and implemented in PICU and had a positive impact on clinician behaviour leading to improvement in selected metrics.

The PRAISe project tested the hypothesis that, together, positive reporting and appreciative inquiry could be used as an intervention to facilitate behavioural change and improvement in the related areas of sepsis management and antimicrobial stewardship.

Is the service effective?

Outstanding ☆ ➔➔

Our rating of effective stayed the same. We rated it as outstanding.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Critical care

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed 10 policies during our inspection which were all in line with best practice based on national guidance. The service followed the Paediatric Critical Care Society (PCCS) Quality Standards for the Care of Critically Ill Children and based their practice around these standards.

The service had a comprehensive audit programme which all staff were encouraged to be involved in. The audit lead had integrated the department audit strategy into a team responsible for PICU projects, the RAISE team (Research, Audit, Quality Improvement, Service Evaluation). The service developed a 'welcome lecture' for new staff to highlight the need for projects to be assessed for suitability and then advised/supported how best to proceed. A central email for this team was available for direct contact. A strategy document for the RAISE team (Research, Audit, QI, Service and Economic evaluation) was also in place. Projects were registered and decision making utilised a decision tool as to what form of project registration was required. Projects were either registered as research (R&D), CARMS (Audit & Service Evaluation), or Quality Improvement (QI).

The department has completed multiple audit projects and contributed to local and national audit (for example healthcare associated infections, unplanned extubations, cardiac arrest reviews, PICANet reporting). These included national audit for fluid management of diabetic ketoacidosis (DKA). DKA is a serious problem that can happen in people with diabetes if their body starts to run out of insulin. When this happens, harmful substances called ketones build up in the body, which can be life-threatening if it's not found and treated quickly. Outcomes of PICU patients with extended (greater than 28 day) stays and usage of paired blood gases in post Norwood procedure in Paediatric Intensive Care.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. There were no children or young people admitted under the mental health act at the time of our inspection. Staff said that it was rare that they would have patients who were subject to the mental health act, however on the occasions that they did, they sought appropriate advice from mental health colleagues and performed risk assessments as required. The paediatric intensive care unit did not have a designated area free from ligature risks, however the service leads said that due to the requirement for one-to-one care and the nature of the patients being treated they would be consistently observed and negate the requirement for such an area. The high dependency unit assessed each patient individually for risks and acted appropriately to ensure those patients had adequate support and access to an advocate should they wish.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The service had a resident psychologist who was available for patients and families but also for staff when they required additional support. The chaplaincy service were also routinely present at multi-disciplinary meetings to provide individualised input where required. We saw during handovers that all needs of the patients, families and staff were discussed and appropriately managed.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had support with nutrition and hydration to meet their needs. Traditional screening tools for determining the risk of malnutrition are not accurate for critically ill children. The service ensured risk assessments were carried out for all patients at risk of malnutrition, for example ventilated patients, regularly and feeding adjusted appropriately.

Arrangements were in place for dietitian support. There was a designated paediatric intensive care unit (PICU) dietitian at 0.5wte. From late 2022 this was to be increased by a further 0.5wte, pending approval to increase the establishment substantively to 1.5wte. Strict criteria were available in the PICU nutrition assessment chart advising staff when to request a dietitian review. The referral policy was incorporated in the PICU nutrition sheet.

Where patients were unable to take oral intake, nutrition support (enteral or parenteral) was started within 48 hours. Patients were assessed during the three daily ward rounds to consider if it was clinically appropriate to start feeds or refer for parenteral nutrition (PN). A ward round checklist was used, which included the question about nutrition.

Patient's nutrition and hydration needs (including those related to culture and religion) were identified, monitored and met. Patients referred to dietetics had a nutritional assessment completed to inform their nutrition and hydration requirements. Part of the assessment included a review of any religious or cultural needs in relation to feed choice and if clinically safe and appropriate to do so, patients were put onto a feed to meet those needs. Where there was no clinically safe and appropriate feed to meet the religious and cultural needs, this would be discussed with the family and consent gained for the use of the clinician's choice of feed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There was a pain score in use in the patient notes. It had been adapted for the service from the Wong-Baker FACES Pain Rating Scale, which is a recognised tool and commonly used for children. The Wong-Baker FACES Pain Rating Scale was created to help children effectively communicate about their pain. Once practitioners clearly understood the child's pain, they developed a treatment and support plan.

Patients received pain relief soon after it was identified they needed it, or they requested it. Staff prescribed, administered and recorded pain relief accurately. The unit used controlled drugs more regularly than many other services due to the complex patient type, therefore they had robust systems and processes in place to enable them to assess, prescribe, access, administer and record all pain relief in a timely and efficient way.

Wherever possible, the word or behaviour the child typically used for pain and whether the child prefers liquid medicine or tablets was documented in the patient's 'Child and Family Profile'. Patients also had a 'Standard for a child with potential for pain' care plan which was documented and adhered to.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits such as the Paediatric Intensive Care National Audit (PICANet).

We saw from the data that the unit's relative rate of emergency readmissions within 48 hours was at 1.09 for the year 2020. Relative readmission rates higher than one indicate that a unit has a higher rate of emergency readmissions within 48 hours than the overall rate for the UK and Republic of Ireland. The service were working on reducing this rate,

however due to the reconfiguration of the unit, the data was slightly higher than the actual number. This is because the unit cared for cardiac patients who were sometimes readmitted for high dependency care on the unit, however this would be logged as a readmission to the PICU. The service were working to understand how to separate those patients in terms of data to show a more accurate picture.

Outcomes for patients were positive, consistent and met expectations, such as national standards. We saw evidence of internal assessment against PCCS standards as well as regular mortality and morbidity meetings and risk management. The service also had a clinical risk team who looked at areas of practice that need improvement.

The main source of national benchmarked data for PICU was the Paediatric Intensive Care Audit Network (PICANet); with the most recent report dated 2021 for the data collection period January 2018–December 2020. PICANet) gathers information on all patients admitted to paediatric intensive care units (PICUs) in the UK and Republic of Ireland, in conjunction with centralised transport services (CTS). BCH PICU mortality data had consistently remained within acceptable confidence intervals over the last four years, when compared with other PICUs contributing to PICANet.

The service reviewed the rate of admissions to intensive care with non-accidental injury during COVID pandemic as part of the service's audit programme. This confirmed there had been a significant increase in the number of admissions to intensive care for children with neurosurgical injury, although the overall number of neurosurgical trauma admissions was not significantly different. There was also an increase in the number of children presenting following a fall from height. Safeguarding referrals for the whole hospital also increased significantly during lockdown. The trust highlighted the increased risk of significant injury through presentation to the regional health and social care network and national dissemination of concerns and risk to children were shared through publication.

Managers and staff used the results to improve patients' outcomes. The service had a substantive, full time quality improvement lead who monitored patient outcomes along with other service leads and used those results to identify learning and risks and then make improvements to the service.

They had a PICU Safety Team QI Management Plan which had four elements, scope, shape, shift, sustain and used this formula to work consistently. Among other improvement methods they regularly assessed whether it was a JDI task ('just do it') or whether there were further elements of support required. The service then monitored the changes for sustained improvement.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment, for example the service saw significant improvement in timely access to medication through their audit process and improvements in systems for access to controlled drugs.

Managers shared and made sure staff understood information from the audits. Staff we spoke with knew about audit programmes and results and were involved in creating new ways of working to address any issues found through audit, such as changes made to the way controlled drugs were managed. Improvement was checked and monitored by the quality improvement team.

The service was accredited as gold by The Extracorporeal Life Support Organization (ELSO), the extracorporeal membrane oxygenation **(**ECMO) international body. The Extracorporeal Life Support Organization (ELSO) is an international non profit consortium of health care institutions, researchers, and industry partners. They provide support to those delivering extracorporeal life support through continuing education, guidelines, original research, publications, and a comprehensive registry of ECMO patient data.

Critical care

The service's teaching was accredited by the paediatric critical care society (PCCS).

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff we spoke with were driven to improve their knowledge and skills to give patients better care. They were proactive in identifying where they felt they were less confident or required additional training. The clinical education team were proactive in approaching staff with new training, skills drills and bespoke inhouse training. The staff had raised that they felt a little uncomfortable when treating tiny babies and felt that they would benefit from some additional training. The clinical education team arranged for a neonatologist to work on the unit once a week to work with the staff, identifying where they lack confidence or skill and addressing these as well as assessing their competence. Staff said that this type of support was invaluable and has given them the confidence and competencies to provide those babies with even better care.

The service created a Tech Team that dedicated their time to supporting the service in a variety of ways. They were founded by operating department practitioners who set up equipment and other support for patients, leaving nursing staff to focus on patient care. At the time of the inspection, the team consisted of a range of staff, some of which rotate from PICU in order to maintain their competencies in setting up of equipment and to better understand each other's challenges and learn other new skills from the team. Staff from both the wards and the tech team said they worked well together and found the tech team a huge support.

The tech team also had responsibility for equipment testing, maintenance and procurement. The service dealt with ordering of equipment and supplies for critical care through their own procurement process, which they said worked well as it was more timely for delivery and they could order supplies most effective/efficient for their patient type.

Managers gave all new staff a full induction tailored to their role before they started work. Staff could work in a supernumerary capacity until they were confident and competent to take on their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge and were supported to do so. Staff were routinely assessed for any deficit in training/competency by the clinical education team and would discuss with staff their preferred approach to resolving any issue. All staff we spoke with said their induction and preceptorship was very thorough and supportive.

The clinical educators supported the learning and development needs of staff. They arranged in house support and training where necessary, such as a neonatologist from the women's hospital to work alongside critical care staff provide support and training.

Managers made sure staff received any specialist training for their role. Any training needs identified were immediately addressed and managers ensured that staffing was adapted to give them time to dedicate to training. Staff told us of opportunities that are available for them to either undertake alongside their role or to take leave from the ward, in each case they felt supported to be ambitious and bring back skills to the team.

Managers identified poor staff performance promptly and supported staff to improve. Where any poor performance had been raised, staff were supported to reflect on their practice and identify themselves what went wrong. In discussion

with their manager, they looked for gaps in learning and the clinical education team joined the discussion to refer for relevant training. If the training did not adequately cover the deficit then staff from all areas and specialities were called upon to provide bespoke training for that staff member or mentoring where appropriate. All staff said their education and development opportunities were vast and accessible.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

All qualified nurses within PICU completed an internal foundation programme within a year of commencing employment. If they had completed one in a previous trust that was accepted if they provided either a stamped certificate from the trust or other proof of learning from an educator.

There were three qualified nurse associates who had also accessed the parts of the foundation course relevant to them. 100% of nurses at band 6 and above had completed the specialist course, with the exception of band 5, who have two cohorts on the course currently who are due to complete in either September 2022 or February 2023. Unfortunately, two cohorts were lost due to COVID and rewriting the course.

Staff were allocated time for the delivery of training and development. A competency framework and training plan ensured that clinicians providing bedside care had or were working towards, and maintaining, competencies appropriate for their role including regular updates annually. This covered paediatric resuscitation, use of equipment as expected for their role, care of children with tracheostomies, care of children needing acute and chronic non-invasive ventilation, and tracheostomy ventilation, care of the intubated child, invasive mechanical ventilation, blood gas interpretation, monitoring and management of analgesia and sedation, haemodynamic monitoring and inotropic support, and care of arterial and central venous lines.

The team took a proactive approach to training and development, recognised where there were potential gaps and could provide bespoke training as well as planned courses and supported staff. Managers at all levels encouraged staff to take on development opportunities and provided them with support together with the education team.

Nurses and non-registered health care staff without previous paediatric critical care experience undertook a structured, competency-based induction programme including a minimum of 75 hours of supervised practice in the critical care unit, a programme of theoretical and bedside education and training ensuring a defined level of competency was achieved within 12 months. Nurses and non-registered health care staff with previous paediatric critical care experience completed a local induction and a review of competence for their role.

Medical and administrative staff were up to date with appraisals while nursing staff were 87% compliant at the time of the inspection. Those staff who had not received their appraisals had a date booked for completion. Staff said they received support through appraisals and performance was monitored and documented.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw multi-disciplinary working across the service, we saw consultant presence on the unit throughout our inspection, pharmacists, play therapists, chaplaincy and psychology. Staff from all disciplines said they were fully involved in patient care from admission and felt that they were all encouraged to be involved in care planning through to discharge and helped to facilitate transition to ward environments for continuity of care. This was evidenced in care records.

Critical care

There was a holistic approach to planning a patient's discharge, transfer or transition to other services, which was done at the earliest possible stage with all relevant teams, services and organisations involved. The service had a multi-disciplinary approach, that included the outreach team, to discharge. Planning for discharge started as soon as possible after admission.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked closely with CAMHS and the local safeguarding teams as well as community care providers and local trusts to provide the most joined up care for their patients.

Due to the complexity of patients being cared for on the unit, most patients were nursed one to one and the service recognised that the nurse allocated to each patient spends the most time with them. Therefore, handovers were nurse led and relevant disciplines were present to review and agree on care plans as a multi-disciplinary team. They worked together to monitor the plans and update as required.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff on wards could call for support from the critical care outreach team seven days a week. The outreach team supported patients to be discharged home earlier than they would be and remain supported in their homes for at least 48 hours, however they could support for longer should the patient require it. The service accessed the outreach team frequently in order to prevent long stays for patients and staff spoke very positively of the team.

The service had access to CT, MRI, ultrasound, X ray, pathology, theatres, a wealth of specialist input as well as chaplaincy and psychology seven days a week. Staff said that they did not have problems accessing any time critical services.

Dietitians worked Monday to Friday between 8.30am and 4.30pm. An emergency service was also provided on Saturday mornings and on call support was accessible 24 hours a day, seven days a week.

In-patient pharmacy services were available on the children and young people's wards and units five days a week during core working hours. At all other times pharmacy advice and support was sought from an on-call pharmacist within the trust.

Occupational Therapists worked Monday to Friday during core working hours. No weekend service was provided.

Nurses led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway and the team agreed on care plans together, they also monitored together for completion or amendments. There was a multi-disciplinary approach for all patients and access to the psychologist and chaplaincy were 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. The high dependency unit had a range of QR codes whereby patients and relatives could access information on a variety of health conditions and where they could be improved with a healthier lifestyle, for example diabetes. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Critical care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent and appropriately recorded consent from children, young people or their families for their care and treatment in line with legislation and guidance. Staff we spoke with understood Gillick Competence and supported children who wished to make decisions about their treatment. Gillick competence refers to the ability of a child or young person under the age of 16 to give consent. Care records showed that children and young people were encouraged to sign consent forms in addition to their parents when this was appropriate.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff ensured that care plans were regularly updated with relevant information to aid decision making.

Staff showed they understood the requirements of the Mental Capacity Act 2015. This act governs decision-making on behalf of young people and adults aged 16 and over who may not be able to make particular decisions for themselves. This may be due to injury or illness that means they do not have the ability to retain and weigh up the information required to make informed care decisions. Over 16s admissions were not common practice but did happen if there was an agreed need.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. The service treated patients up to 16, except in rare circumstances, these were also rarely used within this service due to the nature of the patients being treated, however staff were trained appropriately and knew how to access advice and information.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The trust had a mental health lead and the trust intranet held all policies and guidelines in an easily accessible way. Staff could show where to find the policy and how to obtain advice.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. On the rare occasion that staff had implemented Deprivation of Liberty Safeguards, they told us what this entailed and it was done in line with approved documentation.

Is the service caring?

Good 

Our rating of caring went down. We rated it as good.

Critical care

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff caring for patients who were ventilated and talking to them as they worked, they treated patients and their families with compassion and kindness and respected their privacy and dignity. Staff talked to families to learn the patients' likes and dislikes so that they could personalise their bed space with their favourite characters or bunting spelling their names for example. This information was also used to personalise care plans and updated regularly.

Patients and their relatives said staff treated them well and with kindness. Feedback from patients and families was largely positive, most expressed they had received good care and staff were always attentive, they couldn't ask for more.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. We observed staff move to different areas to discuss confidential information and tried to involve children in conversations, even when they gave no response. We saw staff chatting with parents in a compassionate and sympathetic manner.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told how the chaplaincy service worked closely with the wards to get to know patients and families and provided a wealth of support to patients, families and staff. At the time of the inspection, we were told that there was usually a children's play area at the back of the chapel, however due to the restrictions during the pandemic, it was being used as a food bank for struggling families and also available for staff should they need it.

The chapel was for the use of all staff, patients and families, children are taken from the intensive care unit to be baptised wherever possible rather than being in a clinical environment.

The staff were keen to know the preferences of patients and their families in order to tailor their care most appropriately, we saw evidence of this in care plans.

The trust provided a 'home from home' environment attached to the hospital where patients who were receiving palliative care could be transferred and cared for outside of a clinical environment and could stay there with family and friends in their final days. The 'house' was modern, had all necessary facilities, it was spacious and very quiet.

The service used feedback from parents that 'everyone remembers the first anniversary, but nobody remembers the second'. They created cards to be sent to the families on the second anniversary to let them know they were thinking of them.

The service provided their annual friends and family test data, dated 7 July 2022, which was very positive. We saw feedback such as, "The care given in PICU was great I felt I was able to leave my child if needed and he would be looked after." "They saved our sons life. Nothing was too much to ask. We felt supported all the way through" "All (staff) were amazing and I can't thank them enough. Even when not looking after our son on their shift they came to check on him. They supported us with questions."

There were few suggestions of how the service could improve, however one area of feedback was "I think need more experienced staff for very sick babies ". The service had already proactively addressed this from staff feedback around lack of confidence with tiny babies, they had implemented additional training delivered by the neonatal team and had a neonatologist on the ward to support staff and assess competencies once a week who came from the trust's other site, Birmingham Women's Hospital.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The chaplaincy service did not limit their support to matters of faith. They were available for emotional support as was the psychologist. They had prayer trees in the chapel for families to hang messages, they each had their own avatars for children to access information through a QR code and be shown the information by that familiar avatar.

Patients and families were invited to events for years after they left hospital and could access support for as long as they needed, including support for siblings born post bereavement to help them to understand.

The psychologist was available every day and staff and families spoke very positively of the service and the immediate access should they need it. We heard how the psychologist would often check in with staff as well and patients and families proactively to see if there was anything they needed help with.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. They referred patients and families to the appropriate support should they need it and anticipated those needs so as to have the support on hand.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The staff also understood how difficult it was for children to face their recovery after being critically ill and discussed with them and their families how they could make things easier while they remained in hospital.

Bereavement support was provided by specialist staff. Staff worked with families to provide memory bags and memory boxes. Families could spend time with their child after they had left the ward in the Rainbow room which was a quiet family room. Practical support was also offered which included accessing certificates and helping with funeral arrangements.

The chaplaincy team supported bereaved families, providing emotional support, end of life blessings and they could lead funerals.

Families could choose for their child to be remembered in the remembrance book and were invited to attend remembrance and memorial services and events.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Critical care

Staff made sure patients and those close to them understood their care and treatment. Patients on the paediatric intensive care unit were all nursed one to one and we observed staff talking through everything they were doing in treating the patient. They build up good relationships with families due to being in very close contact and the level of treatment for the patients. On the high dependency unit patients said they felt supported and involved in their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The hospital is located in a hugely diverse geographical area, therefore they regularly used interpreters and said access to the service was good. Many staff were able to speak several languages also, which was helpful for use in an emergency situation.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust created their own app which included an area to give feedback. Patients were provided with a QR code which took them to the feedback section of the app. They monitored the use of this and sought feedback on the use of the system, they found that patients and families preferred the paper method, therefore the service have reverted back to the paper system with the option to feedback electronically. There were also posters with QR codes for information about common conditions, which could be translated into any language.

Patients gave positive feedback about the service. We spoke with three patients and 10 family members who provided largely positive feedback about staff, the environment on the intensive care unit, facilities, support for patients and families and after care. They said they felt the family's wellbeing was always considered alongside their patient and were encouraged to take breaks and go for lunch. They said that had good relationships with all staff from housekeeping to service leaders and nothing was too much trouble.

Staff supported children, young people and their families to make advanced decisions about their care. A palliative care team worked with children, young people and their families when palliative or end of life care was being planned and delivered.

Is the service responsive?

Good ↓

Our rating of responsive went down. We rated it as good.

Service delivery to meet the needs of local people

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

The critical care service leads planned and organised services so they met the changing needs of the local and national population. Managers worked with their local integrated care system to plan and adapt the service to meet local need. Managers also worked with NHS England and their other equivalents for the other UK home nations to plan and adapt the service to meet the needs of children and young people who required specialist care and treatment.

Critical care

Since our last inspection, a range of improvements had been made to the PICU environment. These included for example, a cardiac intensive care area and a reconfiguration of the general paediatric intensive care area to better meet the needs of children and young people. In addition, the service had undertaken improvements through the creation of compartment walls, which had significantly reduced the levels of noise on the busy unit.

NHS England guidance around mixed sex accommodation for children and young people recognises that for many children and young people, clinical need, age and stage of development take precedence over gender. In the intensive care setting the clinical need often took precedence. During our inspection, we saw children of all ages and genders were co-located on the unit we visited, however we did not see any impact and patients and families were happy with this without exception.

Facilities and premises were in line with national standards and were appropriate for the services being delivered. The unit was spacious, with good all round visibility and patients were cohorted as much as possible to allocate the right staff in the right place. Many parents did not wish to leave the hospital, although encouraged, therefore the service provided some refreshments, a quiet area, a shower and could arrange accommodation if families required it. Other local accommodation run by an independent charity was also accessible for up to 60 parents and families. This was free of charge and just a short walk from the hospital.

We received some negative feedback from patients regarding the environment in the high dependency unit. Patients and their families said the environment was a little cramped and dark but recognised that it was an aging building and said that it did not impact on the care that they received, feedback regarding staff in the high dependency unit was overwhelmingly positive.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems and learning disabilities. This support was provided by Forward Thinking Birmingham which was a joint partnership led by the trust.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems and learning disabilities, received the necessary care to meet all their needs.

Staff supported patients living with learning disabilities by using 'This is me' documents and patient passports. Staff showed where the relevant documents were kept in the patient records and that the information was also transferred to the laminated care plans that are kept at the bedside for ease of access.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We spoke with staff throughout the inspection who thoroughly understood the communication needs of disabled patients or patients with sensory loss, however due to patients being treated in critical care, it was more often parents/families that they had to communicate with and use them to help staff understand the needs of that patient in every way. At times that they needed to communicate information to a child they had communication aids to assist.

The service had information leaflets available in languages spoken by the patients and local community. These were predominantly kept electronically but could be provided as a hard copy for patients if they preferred. Access to leaflets

was via QR codes, once the information was sought the language could be changed other languages and staff could print these already translated when required. Video interpretation was available all day and night for four languages through a mobile video system which accessed interpreters from around the world. These four languages were; Arabic, Mandarin, Polish and Spanish. An additional 32 languages were available via video through request and 240 languages were available via audio.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreters were used regularly due to the diversity in the local geographical area, including British sign language. staff and families said they were easily accessible and many staff could speak some of the more common languages of the area. One parent told us that they spoke reasonable English, however in a stressful situation they found it difficult to articulate their questions and properly understand what they were being told. They said they were fortunate that the consultant was able to speak to them in their first language while they waited for an interpreter so that they could understand what was happening and removed some anxiety of waiting and wondering.

Staff had access to communication aids to help patients become partners in their care and treatment.

Patients were given a choice of food and drink to meet their cultural and religious preferences. This was only relevant for the high dependency unit where patients said they had a good choice of food and there were options for vegan, vegetarian, halal amongst other requirements.

The chaplaincy service included representatives from all faiths that make up more than one percent such as Christian, Muslim, spiritual, Hindu, Sikh and Jewish and provided a spiritual/holistic such as meditation and mindfulness support for those who held other beliefs or simply preferred this. There were Muslim prayer rooms and areas where Muslim women could go and spend time alone in prayer.

The ward had dedicated rooms for breaking bad news and relevant training to support staff to do this in the most appropriate and compassionate way, away from the main unit to respect the family's privacy and dignity.

The unit provided facilities for parents such as toilets and a shower, there were facilities for them to eat and drink and have time to themselves while remaining close to their children. They had an emergency accommodation to sleep one family. Staff understood the families need to be close to the patient and that they often wouldn't have eaten for some hours if they had arrived through the emergency department. They put together drinks and chocolate bars to hand to families when they arrived on the units to ensure they had at least had something to eat.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had a multi-disciplinary approach to discharge and planning for discharge started as soon as possible after admission. They were able to discharge some patients home with the support of the outreach team, which meant they could be discharged a little earlier. Some patients who were admitted longer term were reviewed regularly by the entire multi-disciplinary team in order to ascertain whether there were any steps they could take to expedite discharge where the patient was well enough, however there were matters beyond their control in some cases, such as legal proceedings, social or

safeguarding restrictions. The high dependency unit had six beds, therefore if they were at capacity and patients weren't medically fit to move to a ward then this could also impact moves from intensive care. The service monitored the number of delayed discharges (over four hours post decision to discharge), which showed they had remained below the upper limit since December 2021 and continued to manage this so as to minimise the impact on patients.

The service moved patients only when there was a clear medical reason or in their best interest. Staff said that they tried not move patients between the unit and the wards at night and monitored this through audit. The unit was regularly at capacity and moves were at times necessary to provide the most safe and appropriate care to all patients. Bed moves within such an environment can be necessary for a range of reasons, such as infection control, a need for extra space for a particular patient, or a need for quiet for long-term patients. Monitoring shows that where patients were moved, they were coordinated, led by an experienced nurse and supported by the technical team and did not have an impact on their care and treatment. In complex cases a risk assessment was completed. All planned moves were with the family and the service have received no formal complaints or experienced any incidents of harm associated with bed moves nor did the inspectors hear any negative feedback from families in regard to this. Managers monitored that patient moves between wards/services were kept to a minimum.

Staff planned patients' discharge carefully, particularly for those with complex physical, mental health and social care needs using a multi-disciplinary approach to ensure all aspects of care were considered and planned for.

Managers monitored the number of patients whose discharge was delayed, knew which unit areas had the most delays, and took action to reduce them. We saw from data that between January 2021 and January 2022 there were significant fluctuations in the number of delayed discharges which had been impacted by COVID-19. Since February 2022 the numbers have remained stable and consistently lower than the upper limits.

Staff supported patients when they were referred or transferred between services. This included verbal and written handovers and staff escorted the child, young person and their family during transfers as appropriate.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. We saw posters throughout the hospital advising how to make a complaint, raise concerns or leave a compliment and all families we spoke with said they had had such information explained to them on admission. Information on how to complain was also available on the trust's website. This included how to raise a concern through Patient Advice and Liaison Service (PALS) and how to make a formal complaint. This service offered confidential advice, support and information on health-related matters. They provided a point of contact for patients, their families and their carers.

Staff understood the policy on complaints and knew how to handle them. Staff told us they knew how to acknowledge receipt of a complaint and escalate to the relevant manager on the unit for them to provide a response. The service did not receive many complaints; however, all staff knew the process.

Managers investigated complaints and identified themes. The QI team reviewed outcomes from complaints in order to address any themes and make improvements to the service. All staff we spoke with were enthusiastic when discussing service improvements and were proud of how they react as a unit when made aware of any gaps in the service.

Critical care

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaint investigations demonstrated that staff appropriately communicated with complainants throughout the process. Apologies were given to complainants when required and complaint response letters were written in a kind and compassionate manner.

Feedback was shared in newsletters and during huddles, all staff told us that this formed part of their huddles and they were encouraged to discuss complaints to agree on steps to address them where possible.

The service had three complaints between July and November 2021 and no themes found during those.

Is the service well-led?

Outstanding ☆ ➔➔

Our rating of well-led stayed the same. We rated it as outstanding.

Leadership

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

Managers had the right skills to perform their roles effectively. Managers and senior staff told us that management level training was provided to ensure their leadership skills continued to be developed and improved. Staff who aspired to become future leaders could access leadership training to help develop their skills. This ensured there was a proactive approach to succession planning.

PICU service leads told us staffing, skill mix and capacity were their main challenges to sustaining a high quality of care on the unit all of which, had been raised appropriately through the trust's risk management process. Measures were in place to address priorities and issues for example, plans, including a longer-term trajectory, were in place to ensure staff were appropriately trained through internal and external critical care courses.

We spoke with many leads of the service throughout the inspection, staff had good relationships with all levels of leadership which we could see while we were on the units. Staff said that leaders were visible and supportive, they had an open door policy and they were proactive in recognising when staff were struggling.

Managers took a keen interest in their staff and their wellbeing and development, they knew every member of staff well and understood not only their challenges at work but the impact of their challenges at home and considered both to help and support staff wherever necessary.

Critical care

Vision and Strategy

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

The service had a plan in place which set out its vision and strategy for paediatric critical care. A large focus was on working with the operational delivery networks (ODN).

The trust ran a bi-monthly Critical Care Steering Group; a committee of senior clinicians and managers to consider matters relating to the delivery of both paediatric and neonatal critical care.

Additionally, the trust formed part of the West Midlands Paediatric Critical Care Network as the tertiary centre and the provider of a significant share of Level 3 PCC for the region (31 out of 38 beds).

The most recent national GIRFT report on PCC set out a framework which the service had incorporated into its workplan. Whilst the entirety of the GIRFT recommendations were being actioned, the service were particularly focusing on the recommendations relating to commissioning and expansion of Level 2 PCC provision which had been a historical gap.

In May 2022, a submission was made to secure commissioning support for a material expansion to the Trust's HDU+ service (ward based Level 2 PCC staffing to care for specialty patients e.g. cardiac, neuro, liver, neonatal surgical etc). Increased medical posts and expansion of funded nursing establishment was planned to significantly improve resilience and flow within the PICU.

Paediatric critical care worked closely with the KIDSNTS retrieval service who provided PCC transport and clinical advice to the region. The KIDSNTS service was staffed by a number of BCH PICU Consultants.

Outcomes relating to the vision and strategy were monitored by senior leaders in the service to assess progress against the agreed objectives.

Culture

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

There was a positive culture throughout the service without exception. All staff we spoke with and observed were enthusiastic about their role within the service, proud to work there, supportive of colleagues and felt respected, valued and supported. We heard from a number of staff who had undertaken development opportunities that they had either requested or had been offered. Staff said they were encouraged to share ideas for improvement, to take ownership of 'just do it ideas and implement them.

Staff were encouraged to develop their skills and take on leadership responsibilities for experience and learning, to take part on QI projects and research and staff said they were supported when they wanted to take time from their role to gain knowledge and experience in other areas, including rotation.

Critical care

Due to the intense and complex nature of their roles, staff said they are susceptible to burnout, however all staff without exception looked out for one another and took action if others were struggling. The SWell Project (Staff Wellbeing Interventions in Paediatric Intensive Care) was undertaken to understand what helps and hinders wellbeing of staff working in PICU. Learning from this project has improved the wellbeing package for all staff, which was very highly spoken of and was well utilised.

The trust provided a number of networks for staff including, GUARDIANS Network which stands for Guiding Unity and Advocating for Race, Diversity and Inclusion. Their ambition was to proactively work towards zero tolerance on inequalities and discrimination. They hope to provide a platform to lead the way for inclusion by highlighting issues and barriers faced by staff, patients and families. There was a network group aimed at LGBTQ+ staff and their allies and LGBTG+ History Month. DAWN stands for Disability and Wellbeing Network and is an inclusive network to support staff who need support with disabilities, long term sickness and mental health or just need a safe space to talk about their needs and to be heard. Staff we spoke with told us the trust networks were well known and some staff were involved in networks across the wider trust and they fed back information to the unit and took any comments from the unit to the relevant network.

The SWell Project was about Staff Wellbeing in paediatric intensive care. Although there was increased recognition that staff wellbeing was at worrying levels across the healthcare sector, the service found there was little research which defines the qualities of wellbeing or how it is experienced by staff working in Paediatric Intensive Care Units (PICU). The service undertook research which was focused on providing a lived experience definition of wellbeing and to identify the barriers and facilitators to wellbeing in PICU.

Staff were focused on the needs of patients receiving care. We observed staff treating children, young people and their families with compassion and kindness, providing emotional support to children, young people and their families where needed and consistently making sure children, young people and their families understood their care and treatment.

Staff morale was good and celebrating excellence was promoted. Colleagues were encouraged to nominate each other and simple comments were recorded for every member of staff that was recognised by another for their help or support.

Governance

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

Systems were in place to assess, monitor and improve the quality of care within paediatric intensive care. Regular audits were completed to assess and monitor the quality of care. We saw that when quality concerns were identified, action was taken to address these. For example, infection prevention and control audits showed that poor practice such as; occasions where staff were not bare below the elbows and occasional concerns with cleaning were immediately rectified.

Governance structures were in place to effectively manage performance between PICU and the wider healthcare system. Leaders of PICU were active members of the Midlands Critical Care and Trauma Network enabling a ‘helicopter’ view of critical care capacity across partner organisations within the region.

Critical care

The service had a safety team who took responsibility for improvements in safety throughout the service and encouraged staff to spend some time within the team for their own understanding of safety issues and how to resolve them. They carried out research and projects to reach the most timely and effective solutions and took time to embed new ways of working.

Weekly meetings for all units/wards were held with heads of nursing. Staff from critical care who attended these meetings described them as an effective two-way communication where safety, quality and performance concerns could be raised and problem solved and information from senior leaders could be cascaded down to wards, this also provided an opportunity for learning. Following these meetings, ward managers shared updates with the staff through handovers, huddles, team meetings and communications on team boards and newsletters.

Senior leaders within the service fed back significant concerns with the safety and quality of care within the service to the clinical safety and quality assurance committee who met regularly to discuss quality, safety and performance issues. These committees understood their role in monitoring quality, safety and performance within the service. The committee reported directly to the board to ensure they had a regular overview relating to paediatric intensive care. Board reports showed that these committees effectively updated the board on quality issues. For example, the board were cited on serious incidents, their investigations and mitigations implemented to prevent further incidents.

Management of risk, issues and performance

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

Staff knew about and dealt with any specific risk issues. We saw that the service had introduced an electronic key system for access to controlled drugs. They identified risk in the use of standard keys being held by one or two staff members due to the acuity of the patients and their regular requirement to administer controlled drugs. Medication was delayed by time taken to identify the key holder and then access the medication. Also, there was a risk of staff taking keys home or being lost. The quality improvement team worked to find a safer solution and now have the electronic system in place for easy access via individual pin numbers for each registered staff member and the system monitors who has accessed which keys/cupboards at what times. Staff said that this had made a huge impact for both staff and patients.

Staff told us that they were encouraged to contribute to decision making where improvements are concerned. The members of the tech team were responsible for the paediatric critical care procurement, they did not go through the trust procurement process, which they said allowed them to source the right equipment for their patients that are not limited to cost. Staff discussed what worked well and were involved in decisions around service provision and equipment.

We reviewed the paediatric critical care risk register and saw that there were six items listed, three of which related to the risks around controlled drugs. However, the service had the ongoing QI project to address these risks and we heard that they had already been significantly mitigated by introducing the electronic key system and consistent checks.

Others related to acuity of patients and increasing demand for HDU beds; concerns had been raised with regards to if the HDU capacity did not match expansion then the service could not deliver a safe level of care to patients outside PICU. The service had submitted a case for funding and had an alternate ward that they could utilise should they need to. Until

funding was agreed there was nothing further they could do to mitigate the risk. However, the funding would allow middle grade cover for 24 hours a day, seven days a week and the development of a nurse practitioner training programme. The next step would be commissioning of level 2 beds to allow the development of a standalone level 2 unit.

The service had escalation plans in place and made use of the new configuration of the unit which enabled them to isolate areas should they require it. They also explained that should demand surge, they had additional provision in the nearby burns unit which was used during the pandemic so full equipped for critical care.

Minutes of committee and board meetings showed that the highest level of risks within the service were discussed on a regular basis which showed there was senior management and board level oversight of extreme risks.

Mortality and morbidity reviews were regularly completed to review and learn from deaths and other adverse incidents. Staff told us learning was shared from these meetings to ensure learning was shared.

A monthly quality performance report was produced. Items covered included; complaints, incidents, safeguarding and risk. Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division.

Managers monitored staffs' compliance with training and they were aware of gaps in training compliance rates. Where gaps were identified, appropriate action was taken to address these.

Managers told us that individual staff performance issues were addressed in line with the trust's performance and disciplinary policies and procedures.

Information Management

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

Information technology systems were used to monitor and improve patient care. A wide range of information was available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances.

Service performance measures were reported and monitored. Manager's and senior staff had access to these reports and relevant and appropriate service performance information was displayed on boards within the service so that staff and visitors could see at a glance how well the service was performing.

The service shared data securely with external organisations in accordance with legislation. For example, serious reportable incidents were reported to CQC and the National Reporting and Learning System (NRLS) as required. Information was shared internally using a dashboard which was a secure, shared database regarding performance measures and incidents for example.

The service had a business continuity plan which provided guidance on maintaining services and dealing with business interruptions which might disable services or require special arrangements to be put in place to allow them to continue, for example a cyber-attack.

The service was working towards introducing electronic records and electronic prescribing.

Engagement

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

Managers and staff actively engaged with children and families to enable them to plan and manage the service to meet their needs. The service had a range of ways that they could engage with users of the service including the trust app. They found when introducing a digital form for feedback accessed through a QR code, they received a reduction in responses. Therefore, they reverted to the paper format which many children and families prefer. The service used feedback to help quality improvement projects, recruitment and the monitoring of quality.

The service worked effectively with other local and national organisations within the local and wider integrated care systems. This included, other NHS trusts, local authorities, Healthwatch, primary care services and charities. For example, we saw how managers had worked with operational delivery networks helping with coordinating patient pathways between providers over a wide area to ensure access to specialist support.

The Paediatric Intensive Care Unit (PICU) was the lead centre for paediatric intensive care for the West Midlands and the designated paediatric major trauma centre for the West Midlands. In addition, the unit was commissioned to provide Extra Corporeal Membranous Oxygenation (ECMO) for respiratory and heart problems. This meant children could come from further afield to be assessed for this service. A standalone intensive care retrieval service through Kids Intensive Care Decision and support service (KIDS) meant, local and tertiary referrals were accepted from around the region.

Managers and staff worked to raise awareness and address equality concerns. They had a number of networks to support staff and patients which included The Women's Network. The aim of The Women's Network was to provide a safe space for staff members, mutual advice and support, a route for

Learning, continuous improvement and innovation

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

The service had an education team, safety team and quality improvement team who worked well together to achieve the best outcomes for staff and patients. They were proactive and encouraged staff to join their teams on rotation to gain new ideas and understand each other's challenges. We saw boards around the wards showing the improvements that had been made.

Staff told us a number of training opportunities were available to them and most told us they had attended a one hour session that provided a basic introduction to QI, why it was important and how they might get started using the trust's '4S Improvement Model'. Where staff wanted to further develop their knowledge and application of QI, staff told us they could attend a two-part training session; Quality Improvement Bronze Level. This enabled staff to gain the skills to go on to deliver a QI project within their department.

A project manager role had been established in the unit to support QI training, planning and implementation. Under the umbrella of the established PICU Safety Team and in line with the trust governance framework, a local QI management

plan was developed to provide a clear pathway along which prioritised projects would proceed. PICU had been commended for their innovation as a team and staff gave examples of QI projects they had been involved in. These included for example developing, a team leader workbook, a PICU newsletter and the SWell project that looked at interventions for staff wellbeing in PICU.

Staff were enthusiastic when speaking to us about improvements and really appreciated having the opportunities to have real involvement in bringing about change.

Staff participated in local, national and international research and shared research outcomes through posters, conferences and journal publications.

The service had a number of innovative practices for their commitment to learning and improvement of services. Learning from Excellence (LFE) was devised and implemented in PICU. The service found learning from excellence had a positive impact on clinician behaviour leading to improvement in selected metrics.

The LFE project outputs included peer-reviewed publications, social media postings, periodical articles and text-book chapters on positive approaches to safety and quality improvement.

The PRAISe project tested the hypothesis that, together, positive reporting and appreciative inquiry could be used as an intervention to facilitate behavioural change and improvement in the related areas of sepsis management and antimicrobial stewardship.

The PERMIT Study looked at the safety, feasibility and acceptability of early rehabilitation and mobilisation (ERM) on a paediatric Venous-Venous (VV) extracorporeal membrane oxygenation (ECMO) patient. Paediatric ECMO population are commonly exposed to known risk factors that contribute to the phenomenon Post Intensive Care Syndrome (PICS-p). Eighty two per cent of patients leaving PICU had a new functional disability as a direct consequence of their admission.

Patient safety, outcomes and programme efficiency were the driving forces behind the service's QI initiatives. Resources were directed towards the quality and therefore validity of interventions and a dedicated project manager facilitated this. The service promoted that QI with a priority for positive staff experiences fostered engagement and implementation, increased QI capacity, and the opportunity for sustained improvement. They believed that the power and potential of LfEQI lay in its ability to engage staff in meaningful, community driven change for the better thereby improving the quality of quality improvement.

Surgery

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, there were some gaps in the completion of this training.

Nursing and support staff mostly kept up to date with their mandatory training and this training was comprehensive and met the needs of patients and staff. We reviewed the training compliance data for nursing and support staff in 13 wards and departments within surgical services. This data showed an overall mandatory training compliance that fell between 88% and 99% with 10 of the 13 areas showing compliance rates of 95% and above.

Data showed that compliance with training that was delivered through e-learning was much higher than training that was delivered face to face. There were noticeable gaps in nursing and support staffs' basic life support (BLS) training which was delivered face to face. Overall training compliance for BLS training over the 13 wards and departments we reviewed data for was 86%. However, some area's compliance rates fell significantly below this average. For example, nursing and support staff in theatres had a compliance rate of 61% for this training. Theatre staff told us it was hard for them to access this training due to theatre activity pressures. However, team leaders and managers told us they were focussing on addressing these gaps to ensure staff had the skills to work safely within theatres.

Nursing managers we spoke with told us they continuously addressed any gaps in training compliance by prompting staff to complete the training within a specified time frame. We saw examples of this where training reminders and prompts were located in staff rooms and staff told us they found these helpful. This meant systems were in place to maintain and improve training compliance rates.

Data relating to the medical staff working within surgery showed an increased number of training gaps when compared to the nursing and support staff data. Medical staff training data showed an overall mandatory training compliance rate of 77.9%. The lowest compliance rate was 47% for basic life support training and the highest compliance rate was 86% for infection prevention and control training. All of the mandatory training topics compliance rates fell below 90%.

The trust's surgery services had experienced considerable pressures over recent months due to a combination of staff shortages connected with high post-pandemic turnover, COVID related and other absences and the high activity requirements associated with their recovery programme. This had an impact on staff availability to complete mandatory training and the trust had seen this amongst the medical profession.

The trust had taken steps to ensure mandatory training was as accessible, meaningful and efficient as possible to encourage staff to find the time to complete it. The trust also took regular measures to remind staff of their responsibilities both through general communications and messages direct to staff whose training was about to expire.

Surgery

For medical staff, oversight of mandatory/statutory training was carried out within the divisions and reported and monitored through the divisional performance reviews.

In response to medical staff mandatory training performance levels, the following actions were being taken; the clinical service director for surgery issued reminders to all medical staff. The chief medical officer (CMO) contacted every consultant attaching a copy of the training data and requesting improvement to 'green' across the board by September 2022. The CMO emailed every consultant to issue a specific requirement to ensure resuscitation training in particular was updated. The resuscitation lead and committee chair had developed an eight-week plan (to accommodate annual leave over the summer) to target individual medical staff members in surgery shown by the data as out of date (OOD) for resuscitation training and would undertake 1:1 training sessions with staff members as necessary.

Whilst basic life support training compliance was significantly low at 47%. Information received following our inspection showed all medical staff working within surgery had completed, and were up to date with, either European Paediatric Advanced Life Support (EPALS) or Advanced Paediatric Life Support (APLS).

Plans were in place to increase the numbers of staff who were trained in how to support children and young people who lived with a learning disability and/or mental health condition. Staff could access 'we can talk training', designed for acute hospital staff to improve the experience of children and young people in mental health crisis. At the time of our inspection, only 75 staff from the whole of the trust had completed this training. However, a further 250 had signed up and plans were in place to introduce this training for all new starters.

Managers told us a small number of basic awareness of learning disabilities training sessions had been held. A new learning disability clinical educator had recently started working at the trust and was reviewing the training needs for staff around learning disabilities.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The services training compliance data for nurses and support staff for the 13 wards and departments we reviewed all had overall mandatory training compliance that fell between 95% and 100% for safeguarding children (covering levels one, two and three) and 95% and 98% for safeguarding adults (covering levels one and two).

It was noted that nursing and support staff in theatres had lower rates of training compliance for safeguarding children and adults compared to all other areas with compliance rates ranging from 73% for safeguarding children level three. However, plans were in place to address these training gaps.

Medical staff received training specific for their role on how to recognise and report abuse. However, there were significant gaps for this training. Data for this training showed that only 73% of doctors had completed the required level three safeguarding children training and only 75.8% had completed level two adult safeguarding training.

Staff we spoke with told us how they would identify adults and children at risk of, or suffering, significant harm and how they worked with other agencies to protect children, young people and their families.

Surgery

Safeguarding posters were on display in ward areas and staff also knew where to find the trust's safeguarding policies and procedures which were located on the intranet. Staff also knew how to contact safeguarding staff and safeguarding supervision was available to staff to ensure the staffs' learning and support needs were met by staff who specialised in safeguarding children.

Cleanliness, infection control and hygiene

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

All ward areas we visited were clean and had suitable furnishings which were well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Handwashing facilities were located throughout all children and young people's services that we visited. We observed a range of staff including nurses, doctors and allied health professionals follow best practice for PPE and being 'bare below the elbows' when delivering care.

Monthly audits were completed to assess staffs' compliance with infection prevention and control standards and guidance. These audits covered topics that included; hand hygiene, care of vascular access devices and urinary catheters, training and environmental cleanliness. Where concerns had been raised through audits, action plans were in place to ensure the concerns were addressed in a timely manner.

Trust data showed that from April 2022 to June 2022 the average staff compliance rate with hand hygiene across children and young people's surgical services was 99%. Audits showed the actions taken to address areas of poor practice.

Side rooms were available when isolation was required, and staff told us how they would manage the risks associated with transmittable infections. The information staff told us was in line with best practice. We saw barrier nursing being used appropriately to mitigate the risk of the spread of infection. Barrier nursing is when staff provide care for people with confirmed infections with the aim of reducing the risk of transmitting the infection to other people.

Trust data showed that there had been no cases of hospital acquired Clostridium difficile or MRSA from May 2021 to June 2022 in services for children and young people.

Staff worked effectively to prevent, identify and treat surgical site infections.

Environment and equipment

Risks associated with the environment and equipment were not always consistently mitigated. However, suitable facilities were available to children, young people and their families.

Risks associated with the environment and equipment were not always effectively mitigated. Ward nine had multiple unlocked storage areas which contained equipment that could cause harm or could be tampered with. For example, we found a box of batteries in an unlocked cupboard which could have been accessible to any mobile children and young people on the ward. These were immediately removed by the ward manager when we escalated this to them. The ward manager told us they would consider which areas within the ward required locking in response to our feedback.

Surgery

Ward 10 had very limited storage space; therefore, some equipment was stored inappropriately in patient areas. For example, we found three shower chairs, and multiple linen and wash trolleys in the shower room which also contained a toilet that we saw children access. This inappropriate storage created a falls hazard for children and young people accessing the toilet. We shared these concerns with the ward manager who told us the ward really struggled with storage space and that this had been escalated to senior managers.

We also found occasions where the fire exits were blocked with equipment on wards nine and 10. Each time we escalated this, the equipment had either already been removed or was removed in response. This meant fire exits were not consistently left fully accessible in the event of an urgent need to evacuate.

The service had suitable facilities to meet the needs of children, young people and their families. All wards and units were clearly signposted from main corridors. All clinical areas were spacious enough to safely accommodate the needs of the children and young people. In particular, the areas of wards that provided care for children and young people who required increased monitoring and interventions were spacious enough to accommodate the multiple members of staff and equipment needed to manage their complex needs and/or any medical emergencies.

Wards had play areas for children and young people to access and use to play, socialise and relax when required. In addition to this, parents could also access facilities to meet their individual needs. This included; parent kitchens, rest areas and overnight accommodation if required.

Inpatient areas within children and young people's services were locked to ensure the safety of the children and young people. People could only enter the ward by staff within the ward screening them to ensure they were appropriately accessing inpatient areas. Children, young people and their visitors could leave the ward as required/if appropriate by using the exit button or by asking staff to open the doors on their behalf.

The service had enough suitable equipment to help them to safely care for children and young people. A range of resuscitation equipment for use in a variety of age groups in the event of an emergency was readily available in all the areas we visited. We observed regular, recorded checks of this equipment were completed to ensure it was safe and ready to use. Safe space beds were available for children who required a robust and safe bed space to promote their safety if they displayed behaviours that could cause them to harm themselves. One parent told us safe space beds were not always readily available, but staff did their best to obtain these when they were required. One ward manager told us how they had used charitable funds to purchase a safe space bed for their ward so they always had access to one when required.

Staff carried out daily safety checks of specialist equipment. We saw that all equipment, such as; blood pressure monitoring equipment and ventilators were tested regularly to ensure their safety and effectiveness.

We saw that staff followed safe and effective systems to dispose of clinical waste.

Assessing and responding to patient risk

Action was not always taken to ensure risk assessments and risk management plans were consistently recorded for all relevant aspects of care and treatment. When risk assessments and management plans were in place, they were not always updated in response to changes to children and young people's care needs.

Staff identified and quickly acted upon children and young people's risk of deterioration.

Surgery

Assessments to identify and mitigate the risks associated with bed rails were not always recorded by staff in accordance with recommendations made by the Medicines and Healthcare products Regulatory Agency (MHRA). Staff on wards nine and 10 told us this was not something that was routinely recorded. We reviewed the records of three children and young people who were using bed rails on wards nine and 10 and saw no record of appropriate assessment for the safe use of bed rails and no mitigation plans were in place to reduce any risk of harm from bed rails. Two of these children and young people were at increased risk of harm from bed rails due to their size or medical condition. Staff confirmed these assessments had not been completed and recorded in accordance with national guidance. This meant appropriate action had not been taken to protect children and young people from the risk of harm from bed rails.

We escalated our concerns to managers and the trust. The trust confirmed that the current policy that included the use of bed rails was focused on their use in adults rather than children and young people. The trust told us they would adapt the policy to include children and young people and would implement this policy and audit compliance against it. The trust confirmed there had been no recent reported incidents resulting in harm to children and young people through the use of bed rails.

We saw that an unattended child on the ward was regularly accessing the playroom on ward 10 unsupervised. This was not in accordance with the ward's clinical operational policy. The care records for this child did not show that the risks associated with accessing the playroom unsupervised had been assessed and mitigated. This meant we could not be assured that this child was accessing the playroom safely.

Written risk assessments and management plans were completed for appropriate elements of care, including the risks relating to; pressure damage to skin, safe moving and positioning, nutrition and hydration. However, these assessments and management plans were not always updated when children and young people's needs changed meaning up to date information for staff to follow in order to provide safe and consistent care was not always available. For example, one child's moving and handling information recorded that they required four staff members to change their position in their bed. However, staff and the child's parents told us this had changed to two either two staff members or one staff member with support from the child's parent. There was no record to show this had changed or to show that the parent was suitably competent to support the safe repositioning of their child.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. The Paediatric Early Warning Score (PEWS) was used appropriately on the children and young people's wards we visited. PEWS is a tool used to identify signs of early clinical deterioration in children and young people and has different templates for different age groups. We saw that raised PEWS's were escalated appropriately for medical reviews and early intervention was given as required. Staff completed sepsis training to ensure they could complete PEWS correctly and follow best practice for the management of sepsis. The services sepsis training compliance data for the 13 wards and departments we reviewed all had an overall compliance rate of 95%.

Staff could access specialist support from the Children and Adolescent Mental Health Services team (CAMHS) if they were concerned about a child or young person's mental health. The service had 24-hour access to the child and adolescent mental health crisis team and could also access specialist advice from a registered mental health nurse who worked within the emergency department at the trust.

Staff told us how they would manage risks relating to children and young people's mental health. For example, we saw that a child who was at risk of harm from using a standard hospital bed used a safe space bed. Staff told us of the

rationale for the use of the safe space bed. However, the child's care records did not contain reference to the need for this bed through a risk assessment or care plan. This meant that although the risk of harm was being appropriately mitigated, records did not highlight the need for this, which would place the child at risk of not using the safe space bed if they were transferred to another ward without an effective verbal handover.

We saw that risks to children and young peoples' safety were shared and discussed during safety huddles and shift handovers. This ensured staff were verbally updated about how to keep children and young people safe.

Ongoing risks and/or risks relating to discharge were shared with relevant professionals and agencies through discharge coordination meetings and discharge letters.

Nurse staffing

The service had staffing vacancies. However, there was always enough nursing staff on duty with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Managers accurately calculated and reviewed the numbers of nursing and support staff needed for each shift. A safe care tool was used to enable managers to identify the number of staff required to keep children and young people safe. This tool considered the acuity and needs of the children and young people. Staffing numbers were assessed against the safe care tool and risk rated each day to ensure safe staffing. If an area or ward was identified at risk of unsafe staffing, action was taken to address this requesting bank staff or moving staff from wards who were rated as low risk for staffing.

Managers could adjust staffing levels throughout the day and night according to the needs of children and young people. Staffing was discussed throughout the day at management meetings and staffing moves were made to ensure safe staffing across the surgical service.

Data sent to us from the trust showed there were registered nurse vacancies in all 13 areas that we reviewed. This varied from between a 0.1 vacancy on ward 12 to 8.5 vacancies on ward 15 annex. Support staff vacancies were present on nine of the 13 areas we reviewed, these vacancies varied from 0.4 on ward eight and 11 in theatres.

Managers were taking appropriate steps to address vacancy gaps. This included; having a rolling advert out for band five nursing staff, holding recruitment days, trialling rotational posts and streamlining the recruitment process. Managers were also considering different initiatives to try and improve recruitment and retention. This included, considering implementing a nurse retention post and how to incentivise staff to work for the service.

Sickness rates were generally low across the service. The average short term sickness rate across the 13 areas we reviewed was 2.5% and the average long term sickness rate was 3%.

Nursing agency staff were not used. Care and treatment was only provided by staff who were employed by and were familiar with the trust and its processes.

Medical staffing

The service had medical staff vacancies. However, there was always enough medical staff on duty with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

Surgery

Data sent to us from the trust showed there were 10.51 medical staff vacancies within surgical services. 6.92 of these vacancies were at consultant level.

Managers told us they were addressing the consultant vacancies by increasing the numbers of fellowships within the service. Clinical fellows are middle grade doctors who are in the process of becoming more specialised in a defined area. This would enable the service to home grow their own consultants.

Locum doctors were used to temporarily fill medical vacancies as required. Managers told us locum staff received a full induction on arrival at the service.

Staff told us that out of hours consultant support was always available. No concerns with accessing this support were shared with us.

Records

Records were easily accessible to staff providing care. However, records were not always stored securely. Staff kept detailed records of children and young people's care and treatment and these records were clear and up to date.

Records were accessible to all staff providing care. However, records were not always stored securely. We found that records were stored in unlocked cupboards and trolleys on four of the wards we visited. This meant there was a risk that sensitive information about children, young people and their families was accessible to people who may misuse this information. There was also a risk that records could become lost or destroyed when they were not stored securely. We informed two ward managers of our concerns about the security of records during our inspection and although some action was taken to address this, staff continued to not consistently ensure records were secure. We fed this back to the trust at the end of our inspection and they told us they would commence regular checks to monitor compliance with this whilst they waited for the agreed long-term plan of the introduction of electronic care records.

Records contained a contemporaneous account of the care and treatment each child and young person received. This included detailed summaries of communication between staff and parents. All entries we viewed were clear, legible, dated and signed.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service did not always ensure safe systems were followed to prescribe, administer and store medicines.

The trust's policy on the safe prescription of medicines was not consistently followed by staff who prescribed medicines. Medicine prescription charts on wards 9 and 10 did not always contain times for administration by the prescriber. On ward 9 we reviewed the medicines records for three children and young people. Out of 15 regular medicines prescribed to these children and young people only two had prescribed times for safe administration. On ward ten we reviewed the medicines records for two children and young people. Out of 14 regular medicines prescribed to these children and young people only seven had prescribed times for safe administration. This meant there was a risk that staff may not know when to safely give a prescribed medicine and children and young people may not always receive their medicines in a safe manner. We shared these findings with the trust who told us they had taken appropriate action to address this safety

risk. This included communicating the importance of following trust policy and the introduction of audits to assess staffs' compliance with this.

We fund that medicines were not always stored securely on wards nine and 10. We found topical creams were stored on children and young people's bedside tables, meaning they could be accessed by children and young people placing them at risk of harm. We shared these findings with the trust who told us they had taken appropriate action to address this safety risk. This included; immediately ensuring all topical creams were stored securely on wards nine and 10 and plans to amend the trust's medicines policy to appropriately cover the safe storage of topical creams.

Medicines administration records (MARs) contained children and young peoples' weights and allergies to mitigate the risk of unsafe doses and exposure to allergens.

Controlled Drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, administered and recorded following local and national guidance.

Temperature sensitive medicines were stored safely. The temperatures of medicines rooms and medicine refrigerators were regularly recorded and monitored and we saw that medicines were stored within the recommended temperature range. There was a system in place to ensure any deviations from safe temperatures were acted upon immediately and staff were aware of what action to take if the temperatures were not safe for medicine storage.

Resuscitation 'crash' trolleys containing emergency medicines and equipment were securely stored, but available and accessible if needed in an emergency. Checks were in place to ensure emergency medicines were available and safe to be used.

Pharmacy support was provided to ensure regular reviews of children and young people's medicines occurred and they also provided specific advice to the staff, children, young people and their families about their medicines.

The service had effective systems in place to ensure staff knew about safety alerts and incidents.

Incidents

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

Staff knew what incidents to report and how to report them. Staff told us there was a 'no blame' culture at the service which meant all reportable incidents were reported in line with national reporting requirements and trust policy.

Never events were also reported as required. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

NHS England's web-based serious incident management system known as Strategic Executive Information System (StEIS) shows that between June 2021 to June 2022, the trust reported three never events that related to surgical services for children and young people. Two related to retained foreign objects post-procedure and one related to wrong site surgery.

Surgery

Incidents were investigated in a timely manner and children, young people and their families were encouraged to be involved in this process. Lessons learned were identified and shared within the service and trust to reduce the risk of similar incidents from occurring. We reviewed three root cause analysis/incident investigations relating to three serious incidents that had occurred within children and young people's services. These detailed the causes of incidents and the actions required to prevent further incidents from occurring.

De-briefs were facilitated by senior clinicians and managers following serious incidents and never events to ensure staff were supported through the incident management process.

Staff received feedback from the investigation of incidents and we saw that themes and learning from incidents were effectively filtered down to all staff within the service through safety huddles, newsletters and emails. This also included the sharing of national patient safety alerts that had resulted from incidents from other external sources.

Staff understood the duty of candour (DoC) regulations and the procedure for following it. Managers and clinicians were responsible for ensuring that relatives were informed following an incident. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that patient. Incident reports recorded when the DoC procedure was required/had been followed.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, the observation, monitoring and escalation policy was based on national guidance. This policy provided staff with appropriately nationally recommended monitoring templates and provided guidance for staff to follow to ensure post-operative observations were made. Post-operative observations were in line with the Royal College of Nursing's 'standards for assessing, measuring and monitoring vital signs in infants, children and young people'.

Clinical pathways were in place which were based on best practice and national guidance. For example, a Children's Epilepsy Surgery Service (CESS) pathway was in place at the service which was based on best practice and national guidance which included National Institute for Health and Care Excellence (NICE) guidance.

Multidisciplinary clinical practice and quality assurance groups met on a regular basis to discuss and review clinical policies and guidelines. This meant there were regular reviews to ensure policies and procedures were based on the most up to date guidance.

Surgery

Managers monitored compliance with policies and procedures through a programme of audits and case reviews. For example, full reviews were completed for all children and young people within the service who had been identified as having a blood borne infections, including sepsis. Care records were reviewed to identify if the relevant policies and procedures were followed and learning opportunities were identified and acted upon as required.

Staff protected the rights of children and young people subject to the Mental Health Act (MHA) and followed the Code of Practice. There were no children and young people admitted under the MHA in the areas we visited at the time of our inspection. However, staff told us how they worked closely with the mental health liaison team if a child or young person required assessment or treatment under the Act. Staff ensured the mental health needs of all children and young people were effectively shared during staff handovers.

Nutrition and hydration

Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure children and young people fasting before surgery were not without food for long periods. The service made adjustments for children and young peoples' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Children and young people told us they had a choice of suitable foods and drinks throughout the day. We saw that special dietary needs were met in all areas of the children and young people's service that we visited. This included consideration of children and young peoples' religious, cultural and other needs.

Parents rooms in all areas of the service were stocked with bread and hot drink supplies, which meant parents could make snacks and hot drinks as required.

Breastmilk was stored, labelled and administered in a safe manner. Mothers who were breastfeeding were able to eat from the hospital menu with their child. This ensured breastfeeding mothers were supported to access adequate nutrition to help promote healthy breastfeeding.

Staff assessed and monitored children and young people's risks relating to nutrition. Records showed that weights were regularly recorded as required to enable effective monitoring of the risk of malnutrition. National guidance was followed to ensure children and young people fasted for the recommended period of time prior to surgery.

Care records showed that staff fully and accurately completed children and young peoples' fluid and nutrition charts where needed. These records also showed that referrals to specialist staff such as dieticians and speech and language therapists (SALT) were made in a timely manner when a nutrition risk was identified.

Medicines administration records showed that enteral nutrition (nutrition delivered through tubes, such as; nasogastric tubes (NG's) and percutaneous endoscopic gastrostomies (PEG's)) and parenteral nutrition (nutrition delivered intravenously through veins) was administered as prescribed.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Surgery

Staff assessed children and young peoples' pain using nationally devised tools and gave pain relief in line with individual needs and best practice. For example, a pictorial pain scale was used to help younger children communicate their pain to staff.

Advice and support from the trust's pain management team could be accessed as required. The pain management team was formed of pain nurses and anaesthetists, who helped to look after children who were in pain after their operation. This team worked closely with ward staff to make sure that children and young people were as comfortable as possible.

Children and young people told us their pain was well controlled. Effective systems were in place that ensured children and young people were asked about their pain and observed for signs of pain during regular comfort rounds throughout the day and night. MAR's showed that pain medicines were administered as required.

Patient outcomes

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

The service participated in relevant national clinical audits. However, these audits were very limited as minimal national audits relating to children's and young people's surgery were available. The service submitted data to the National Institute for Cardiovascular Outcomes Research (NICOR) and participated in the congenital heart disease in children and adults. Between April 2020 to March 2021 the service performed 793 procedures. The service's 30-day survival rate was 98.9%. This meant the mortality rate for congenital heart disease procedures was 1.13% which was lower than the national average which was 1.6%. The data quality score from the NICOR audit was 99.5% which NICOR report stated was and excellent score that showed robust processes were in place to ensure good quality data standards were maintained.

Locally designed audits were completed to monitor outcomes for children and young people. Outcomes for children and young people were mostly positive, consistent and met expectations, such as national standards. For example, a post tonsillectomy bleed rate audit had been completed for tonsillectomies performed in 2021. 516 tonsillectomies had been performed with a readmission rate of 4.06% and a 1.74% bleed rate. The 2019 Getting It Right First Time (GIRFT) ear, nose and throat surgery speciality report cited that the average readmission rate for children and young people's tonsillectomies was 9.4% which meant this service's readmission rate was lower than the national average. The local audit data showed two thirds of the children and young people who bled post procedure did not require surgery and none of the children and young people required a blood transfusion for their bleeding.

Audit results were shared with relevant staff groups through team meetings or formal learning and development activity, such as medical staff education sessions. This included audit recommendations and lessons learned.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Competency frameworks that were specific to each ward/area were in place and completed by all staff. These were reviewed annually to identify if any updates or further training was required.

Surgery

Managers supported staff to develop through yearly, constructive appraisals of their work. The services appraisal data for the 13 wards and departments we reviewed all had overall average appraisal rate of 95.6% for nursing and support staff. Appraisal rates across the wards and areas that fell between 83.9% and 100% with nine of the 13 areas showing appraisal rates of 95% and above.

Medical staff working within children's surgical services had an average appraisal rate of 90%. Managers told us gaps in appraisal compliance were being addressed by working with staff to get overdue approvals booked.

Staff told us their appraisals were effective because they helped them to identify and plan their training and development needs. Staff also told us they could request supervision sessions with senior staff/managers, to provide them with any support and feedback needed to enable them to work effectively in their roles.

Managers gave all new staff a full induction tailored to their role before they started work. Staff who had recently joined the service confirmed this.

Staff told us they could access specialist and/or additional training when required. For example, some ward staff had been trained in recovery skills to enable children and young people to recover on the wards in a safe manner. This helped to support flow within theatres, but also enabled children and young people to recover in an environment they were more familiar with. Additional training was also provided within theatres to enable some surgical staff to work in dual roles, such as scrub and recovery roles. This broadened the competencies of this staff group and provided staff with a more diverse role. It also enabled more flexibility with staffing which helped with flow through theatres.

Theatre staff told us how they had participated in simulation training where they received training in how to deal with emergency situations that could occur within the theatre environment. They told us how this kept them skilled to manage emergency situations effectively as a team.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Professionals involved in these meetings included; nursing and medical staff, allied health professionals (such as physiotherapists, occupational therapists, dietitians and speech and language therapists), safeguarding staff and discharge coordinators.

We saw that children and young people with multiple and/or complex care needs due to polytrauma (when a person experiences injuries to multiple body parts and organ systems) and/or long-term conditions were seen by staff from multiple specialities as required. Effective communication between specialities was evident when we reviewed care records.

Staff also worked with other agencies when required to care for children, young people and families. For example, records showed that appropriate and timely referrals were made to the local authority and community teams as part of effective discharge planning.

Staff referred children and young people for mental health assessments when they showed signs of psychological ill health, depression.

Surgery

Seven-day services

Key services were available seven days a week to support timely patient care.

There was medical cover on-site 24-hour hours a day, seven days a week. In addition to this, consultants were also available on an on-call basis out of hours. Staff told us they could call for support from consultants at any time and reported no delays in receiving this support.

Radiographers and physiotherapists were available 24 hours a day, seven days a week as an on-call rota was in place to facilitate this. This meant diagnostic X-rays and respiratory physiotherapy could be completed promptly when required.

The child and adolescent mental health team was also accessible through the crisis team 24 hours a day, seven days a week.

Dietitians worked Monday to Friday between 8.30am and 4.30pm. An emergency service was also provided on Saturday mornings and on call support was accessible 24 hours a day, seven days a week.

In-patient pharmacy services were available on the children and young people's wards and units seven days a week during core working hours. At all other times pharmacy advice and support was sought from an on-call pharmacist within the trust.

Occupational Therapists worked Monday to Friday during core working hours. No weekend service was provided.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. This included healthy eating and infection prevention and control information in relation to Covid 19.

The trust's website contained healthy living information. For example, an NHS app was promoted to help children, young people and their families make healthier food choices. The website also contained information to show brain tumour awareness month had been celebrated in March 2022. Signs and symptoms of brain tumours were highlighted alongside treatment pathways, including an introduction to ward 10 which is where children and young people would be admitted for brain surgery.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. Care records showed that appropriate pre and post-operative advice and support had been given to children, young people and their families to ensure children and young people were as fit as possible for planned surgery and had the information they needed to facilitate their recovery on discharge.

Consent, Mental Capacity Act

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

Surgery

Staff made sure children, young people and their families consented to treatment based on all the information available. Children, young people and their families told us how staff explained care and treatment options in a manner that helped them to understand. They told us they were encouraged to be involved in making decisions about their own care and treatment when this was appropriate.

Staff gained consent and appropriately recorded consent from children, young people or their families for their care and treatment in line with legislation and guidance. Staff we spoke with understood Gillick Competence and supported children who wished to make decisions about their treatment. Gillick competence refers to the ability of a child or young person under the age of 16 to give consent. Care records showed that children and young people were encouraged to sign consent forms in addition to their parents when this was appropriate.

Staff showed they understood the requirements of the Mental Capacity Act 2015. This act governs decision-making on behalf of young people and adults aged 16 and over who may not be able to make particular decisions for themselves. This may be due to injury or illness that means they do not have the ability to retain and weigh up the information required to make informed care decisions. Over 16s admissions were not common practice but did happen if there was an agreed need.

Staff told us they received and kept up to date with training in the Mental Health Act and Mental Capacity Act through regular safeguarding training.

Staff shared examples to demonstrate that when children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions.

Is the service caring?

Good ↓

Our rating of caring went down. We rated it as good.

Compassionate care

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

Children, young people and their families said staff treated them well and with kindness. We observed that interactions between staff and children, young people and their families were consistently delivered in a kind and compassionate manner. The latest annual report that analysed friends and family test feedback for surgical services showed that 98.5% of respondents said they rated the care they received from staff to be very good or good. 98% of respondents said they rated the attitudes of staff as very good or good.

Staff were responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We saw staff of all grades and disciplines spend additional time with children and young people who were on the wards without parental presence. We saw that this additional support made these children happy as they responded positively to this team approach.

Surgery

Staff promoted and protected the privacy and dignity needs of children, young people and their families. We saw curtains were drawn around bed spaces when care and treatment was delivered and private spaces were accessed when required to have sensitive conversations with children, young people and their families.

Some children and young people received care and treatment in closely monitored beds where they where they were recorded visually and auditory (this related to beds where children and young people's seizure activity was closely monitored as part of their care and treatment pathway). Staff were aware of how to support these children and young people to use commodes and urinals in a section of the bed space that was not in view of the camera. Staff told us they only accessed and retained film and auditory data post discharge that contained seizure activity. All other recordings were deleted.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. We saw staff display a non-judgmental attitude when caring for children and young people with diverse backgrounds and complex and challenging medical conditions. This included the provision of care and support to children and young people who displayed behaviours that challenged the staff.

Staff told us how the chaplaincy service worked closely with the wards to get to know and support children, young people and their families. The chaplaincy service included representatives from all faiths including; Christian, Muslim, Hindu, Sikh, Buddhism and Judaism. The team could be accessed 24 hours a day, seven days a week. A multifaith chapel and a Muslim prayer room was available on the main children's hospital site for children, young people, their families and staff to visit. In addition to the faith and emotional support provided by the chaplaincy service, they also offered practical support by providing a food bank in the chapel to support children, young people, their families and staff.

Emotional support

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

Staff gave children, young people and their families help, emotional support and advice when they needed it. They supported children, young people and their families when they showed signs of distress. This included supporting a young person and their parent during an emergency situation and also supporting a child who had received a treatment that they found uncomfortable and distressing. We saw that children, young people and their families were supported at times of distress in a manner that promoted their privacy and dignity.

Young people and their parents told us that staff broke bad news to them in a sensitive manner, demonstrating empathy and compassion.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing. One parent told us and care records evidenced that referrals for psychological support were made for parents when appropriate as well as children and young people. Specialist nurses provided children, young people and their families with emotional support alongside their specialist practical support.

Bereavement support was provided by specialist staff. Staff worked with families to provide memory bags and memory boxes. Families could spend time with their child after they had left the ward in the Rainbow room which was a quiet family room. Practical support was also offered which included; accessing certificates and helping with funeral arrangements.

Surgery

The chaplaincy team supported bereaved families, providing emotional support, end of life blessings and they could lead funerals.

Families could choose for their child to be remembered in the remembrance book and were invited to attend remembrance and memorial services and events.

Understanding and involvement of patients and those close to them

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

Staff consistently made sure children, young people and their families understood their care and treatment. Without exception all the children, young people and families we spoke with told us they knew why they were in hospital and confirmed that their treatment choices were explained to them in a manner that helped them to understand. Two young people told us they had been encouraged to consent for their care and had signed consent forms themselves which made them feel in control of their care.

Theatre staff told us how they supported children and young people with hearing loss when they attended theatre. Staff used clear masks to ensure children and young people who lip read, could still communicate and be involved in their care.

Parents told us and care records showed that they were supported by staff to learn how to deliver care to their child in preparation for discharge. For example, one parent told us they had been shown how to complete stoma care and another parent told us they had been taught to administer enteral nutrition (nutrition delivered through tubes). Care records for both these children showed the parents had received training and had either been signed or in the process of being signed off as competent or in the process. The trust's website contained links to information leaflets and videos relating to some surgical procedures and services. For example, videos were accessible to parents to support them in understanding the purpose of a gastrostomy and how to care for a child with a gastrostomy. A gastrostomy is a tube that goes into the stomach via the abdomen. It's most frequently used for enteral feeding purposes.

Staff also told us how they had provided bespoke guidance for a parent who required visual instructions to enable them to learn how to safely feed their child through a feeding tube. This was laminated for the parent to use on the ward and on discharge. After receiving positive feedback from the parent this additional guidance is now offered to other parents whose leaning style may benefit from the additional guidance.

Staff supported children, young people and their families to make advanced decisions about their care. A palliative care team worked with children, young people and their families when palliative or end of life care was being planned and delivered.

Patients gave positive feedback about the service. The latest annual report that analysed friends and family test feedback for surgical services showed that 97% of respondents said they rated the overall experience of their care to be very good or good.

Is the service responsive?

Good ➔➔

Surgery

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local and national population. Managers worked with their local integrated care system to plan and adapt the service to meet local need. Managers also worked with NHS England and their other equivalents for the other UK home nations to plan and adapt the service to meet the needs of children and young people who required specialist care and treatment. For example, the service's liver and small bowel ward provided care and treatment for children and young people from local area, the rest of the United Kingdom and Europe. Managers at the service had recently been responsive to a national increase in Hepatitis in Children. Hepatitis is inflammation of the liver caused by a viral infection. The service had successfully adapted the way the liver and bowel ward operated to address an increase in demand for liver care and treatment.

The service worked effectively with medical consultants from other NHS trusts in providing specialist advice to fellow professionals in the UK and overseas. There was an agreed referral protocol to access this specialist advice.

Staff knew about and understood the standards for mixed sex accommodation. However, we could not be assured that mixed sex breaches would be reported as children and young people's preferences in terms of mixed gender accommodation was not consistently recorded. Staff told us that they followed NHS England guidance around mixed sex accommodation for children and young people. This guidance recognises that for many children and young people, clinical need, age and stage of development take precedence over gender. The guidance recommends that children and young people should be given the choice as to whether they wish to be segregated according to age or gender. During our inspection, we saw children of all ages and genders were co-located on the wards we visited. Children, young people and their families told us they did not recall being asked whether this was their preference, and care records did not record that a choice had been offered. However, without exception all children and young people told us they were happy with where they received their care.

Facilities and premises were appropriate for the services being delivered. Indoor and outdoor play areas were available to children and young people either on their wards or at the play and admissions centre. Play specialists supported children and young people and play was used as a way of not only entertaining children, but as a therapeutic tool to help them understand their illness and treatment and help their development.

Teachers from a local specialist academy taught children and young people at their bedsides. A classroom was also available that enabled children and young people to take exams under the required conditions.

The service relieved pressure on other departments by enable children and young people to access day case surgery. Day case surgery was planned and completed when appropriate to ensure children and young people only required in-patient stays when this was necessary. This meant many children benefited from streamlined care and treatment that enabled them to be away from their home environment for the least amount of time possible, causing less disruption to their and their families routine.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health conditions and learning disabilities. This support was provided by Forward Thinking Birmingham which was a joint partnership led by the trust.

Surgery

Meeting people's individual needs

Children, young people and their families' individual care preferences were not always recorded to show these had been assessed and responded to. However, the service was inclusive and staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Systems were in place to enable children and young people living with additional needs resulting from; mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. However, we found these systems were not always accessed by staff in a timely manner to ensure they had access to the information they needed to effectively support children and young people with additional needs. For example, hospital passports were available for children, young people and their families to complete. A hospital passport provides important information about a patient with an additional need such as a learning disability, including personal details, the type of medication they are taking, and any pre-existing health conditions. The passport also includes information about how a person communicates and their likes and dislikes, which can be very important when they are first admitted to hospital. We spoke with two children, young people and their families who required a hospital passport. One young person had been given their passport in a very timely manner and the other had been given theirs on the day of our inspection which was 17 days after their admission.

Staff, children, young people and their families could access specialist support from a learning disability liaison nurse when required. We saw that this nurse was visible on the wards and staff knew how and when to contact them for support and advice.

Care records did not always contain information about the individual needs and preference of children and young people. The lack of individual preference information was more significant for children and young people who were unaccompanied by their families. We looked at the care records of two children and young people whose families were not always present on the wards. Neither of the care records for these children contained information about their likes, dislikes and preferences meaning staff did not have information to care for them in line with their individual preferences in a consistent manner.

Generic care plans were used. Space was available to personalise these care plans by putting the child or young person's name within them. However, these were frequently left blank meaning there was an inconsistent approach to personalising the care plans.

We raised the concerns around care records not always being person centred and detailed in terms of individual preferences to the trust during our inspection. They told us they would review care record templates to ensure individual preference could be effectively recorded, remind staff to consistently enter children and young people's names on all pages of the care plans contained in the care records and they monitor staff compliance with this through regular audits.

Wards were designed to meet the needs of children, young people and their families. Pictorial prompts were located on the children's wards to help orientate children and young people to key areas such as the bathroom. Staff told us these also assisted parents who could not read or whose first language was not English to orientate themselves to the ward.

Children and young people who were anxious about going to theatre could access a portable gaming system to keep them distracted during their transfer and induction to theatre. Play specialists staff could also be requested to support children within the theatres environment as required to minimise their anxiety and distress.

Surgery

Parents and carers could sleep next to their children or young person on fold up beds if this was what the child, young person and their family requested. Separate parent accommodation on site was available, free-of-charge. There were nine twin rooms and four single rooms. Rooms were usually available for parents whose children were very poorly or if there were particular considerations, such as if parents did not live in the local area or if there were accessibility concerns relating to disabilities. Other local accommodation run by an independent charity was also accessible for up to 60 parents and families. This was also free of charge and just a short walk from the hospital.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff told us they could access interpreters. However, they said accessing interpreters in urgent and emergency situations was sometimes challenging. Video interpretation was available all day and night for four languages through a mobile video system which accessed interpreters from around the world. These four languages were; Arabic, Mandarin, Polish and Spanish. An additional 32 languages were available via video through request and 240 languages were available via audio.

Staff told us they could request access to information leaflets available in a variety of languages spoken by the children, young people, their families and local community.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. For example, vegan and halal meals were available if and when required.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. For example, we saw Makaton resource files were available for use on wards to enable staff to communicate with children and young people who used Makaton to communicate their needs. Makaton is a unique language programme that uses symbols, signs and speech to enable people to communicate.

Staff told us how consultants worked flexibly to meet the individual needs of children, young people and their families. For example, the parents of a child could only both attend the hospital at weekends, therefore the consultant came in outside of their standard working hours at a weekend to speak with both parents together.

Staff used transition plans to support young people moving on to adult services. A trust policy was in place that provided staff with clear guidance on how to plan for and manage the transition of children and young people into adult services. This planning commenced (if appropriate) when a child reached 11 years of age and transition planning continued until the young person was 16 (or older if the young person lived with a learning disability). Resources were provided to children, young people and their families to educate them about the transition process and individual transition plans were developed for each child, young person and their family.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers monitored waiting times and aimed to ensure children, young people and their families could access services when needed. Referral to treatment time (RTT) results were lower than the national target. However, this is in line with the national picture for RTT as all providers recover from Covid 19 backlogs. RTT is how health services are monitored to

ensure they meet the 18-week pledge to provide a patients first treatment. The service closely monitored it's RTT performance, and trust data showed that between June 2021 and May 2022 the overall average RTT for children and young people's surgical services was 72.7% ranging from 70.7% and 74.8%. The service had an appropriate RTT recovery plan in place to improve RTT outcomes.

Managers worked to keep the number of cancelled surgeries to a minimum. Data from the service showed there had been 469 cancelled surgeries between July 2021 and June 2022. Cancelled surgeries varied from 26 and 53 per month and was closely linked to staffing absences which were linked to Covid 19. The most common reasons for cancellations were staff availability and prioritisation of emergency surgeries. When children and young people had their surgeries cancelled at the last minute, managers made sure they were rearranged as soon as practically possible. However, this was not always within the national target of 28 days. When this target was not met the service reported these cases as breaches and took action to address these breaches.

The service moved children and young people between wards only when there was a clear medical reason or in their best interest. Moves within wards were made as children and young people required less monitoring. For example, some children and young people required periods of care in high observations on a ward before being moved to another area of the ward as they recovered.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Staff started planning each child and young person's discharge as early as possible, particularly for those with complex mental health and social care needs.

Managers effectively monitored the discharge planning for children and young people through daily bed capacity and weekly long stay meetings. The service reported no surgeries had been cancelled within the previous 12 months due to delayed discharges.

Staff supported children, young people and their families when they were referred or transferred between services. This included verbal and written handovers and staff escorted the child, young person and their family during transfers as appropriate.

Learning from complaints and concerns

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

Children, young people and their families told us how they would complain or raise concerns. Without exception everyone we spoke with told us they would be happy to approach any staff member to share concerns. One parent told us how they had raised concerns with a ward manager and was happy with their response.

Information on how to complain was located on all the wards we visited and was available on the trust's website. This included how to raise a concern through PALS and how to make a formal complaint. PALS stands for the Patient Advice and Liaison Service. This service offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Staff told us they would record and escalate concerns or complaints that had been shared with them to ward/unit managers or other senior staff.

Surgery

We reviewed three complaint investigations that had concluded between June and August 2022 and found they were investigated appropriately and in accordance with the trust's complaints policy. Complaint investigations demonstrated that staff appropriately communicated with complainants throughout the process. Apologies were given to complainants when required and complaint response letters were written in a kind and compassionate manner.

Staff told us that lessons were learned from complaints and concerns. Learning was shared in safety huddles, handovers and newsletters.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

Managers had the right skills to perform their roles effectively. Managers and senior staff told us that management level training was provided to ensure their leadership skills continued to be developed and improved. Staff who aspired to become future leaders could access leadership training to help develop their skills. This ensured there was a proactive approach to succession planning.

Managers and senior staff displayed the qualities required for effective leadership. This included being approachable and accessible. Most staff told us that managers and senior staff were visible in all the areas we visited. The only exception to this was in theatres where staff reported reduced visibility of senior staff. All the staff we spoke with told us they felt supported and valued by their managers.

Leaders understood and managed the priorities that the service faced. For example, they encouraged and supported staff to develop new ways of working to address access and flow issues. This included the trialling and implementation of High Intensity Throughput Theatre (HITT) lists to aid recovery of surgical referral to treatment times post pandemic.

Vision and Strategy

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

The service had a plan in place that set out its vision and objectives for 2022 and 2023. The plan focused on areas that included; performance, quality, partnership working and the promotion of a happy and productive workforce. Example objectives included; an aim to achieve 80% theatre session utilisation across all services and the aim to actively engage in the Surgical Operational Delivery Network and become the lead specialist paediatric provider in the Network.

Surgery

The surgical vision and strategy had a focus on engagement with others to ensure patients and key groups, such as staff and integrated care boards and systems were involved in this process.

The service's vision and strategy was aligned to the relevant key priorities of the local integrated care system (ICS). This included one of the ICS's key priorities of, 'Delivering significantly more elective care to tackle the elective backlog'.

Outcomes relating to the vision and strategy were monitored by senior leaders in the service to assess progress against the agreed objectives.

Culture

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

We saw there was a positive open culture. Staff told us and we saw that they openly reported incidents as there was a no blame culture at the trust. Staff told us they felt incident reporting was an opportunity to improve care and reflect on their practice. We saw that incidents were discussed openly during safety huddles and handovers and reflection and learning was encouraged in response to incidents.

The service promoted a positive and welcoming culture. An image of a tree alongside the acronym based on the word 'grow' was used on internal communications with the staff withing the surgical group. Grow stood for; great communication, recognition for all, our teams, welcome everyone'.

All the staff we spoke with were aware of and displayed the trust's values. These were; 'ambitious, brave and compassionate'. These values were displayed throughout the service for children, young people and their families to see. In addition to the trusts values some ward and areas had devised their own ward specific values. For example, ward 10's values were in an acronym style based on the word 'brain' as ward 10 was a neurosurgical ward. Brain stood for, 'bold, reliable, affirmative, inspirational and nice'. Staff from ward 10 told us they had been involved in the design of these values and they were words that they wanted to embody for the children, young people and families they cared for.

Staff were focused on the needs of patients receiving care. We observed staff treating children, young people and their families with compassion and kindness, providing emotional support to children, young people and their families where needed and consistently making sure children, young people and their families understood their care and treatment.

Staff morale was good. Staff survey results from 2021 showed that staff working within surgery had a higher morale score than the trust average.

Excellence was recognised and promoted. Annual staff awards are held to recognise and celebrate members of staff who provide exceptional care. In 2021 there were over 600 nominations received which demonstrated a culture where staff are proud of the work that they and their colleagues do. A ward manager from surgical services won the best boss award at the 2021 awards which demonstrated on how much their team valued them. Children, young peoples, families and staff were also encouraged to nominate staff/colleagues for monthly staff awards for displaying trust values and providing exceptional care.

Surgery

Governance

Systems were in place to assess, monitor and improve the quality of care within children and young people's surgical services. However, these were not always effective in identifying safety concerns. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Systems were in place to assess, monitor and improve the quality of care within children and young people's surgical services. Regular audits were completed to assess and monitor the quality of care. We saw that when quality concerns were identified, action was taken to address these. For example, infection prevention and control audits showed that poor practice such as; occasions where staff were not bare below the elbows and occasional concerns with cleaning were immediately rectified.

However, some of the systems in place to assess, monitor and improve quality were not always effective in identifying safety concerns. For example, audits had not identified that trust's medicines management policy was not consistently followed by staff and environmental audits had not identified care records were not always stored securely.

Weekly ward manager meetings were held with heads of nursing. Staff who attended these meetings described them as an effective two-way communication where safety, quality and performance concerns could be raised and problem solved and information from senior leaders could be cascaded down to wards. Following these meetings, ward managers shared updates with the staff on the wards through handovers, huddles, team meetings and communications on team boards.

Senior leaders within the surgery service fed back significant concerns with the safety and quality of care within the service to the clinical safety and quality assurance committee who met regularly to discuss quality, safety and performance issues. These committees understood their role in monitoring quality, safety and performance within the service. The committee reported directly to the board to ensure they had a regular overview of quality, safety and performance relating to children and young people's services. Board reports showed that these committees effectively updated the board on quality issues. For example, we saw the board had been cited on never events that had occurred within the service and the action taken to mitigate the risk of further incidents from occurring.

Management of risk, issues and performance

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

Organisation and patient safety risks were identified and recorded on the service's risk register. Each risk was assigned a risk score and level based on its severity and a mitigation plan was put in place to mitigate the risk. For example, the risk of being unable to recover services to pre Covid levels had been categorised as a red risk which was the highest level of risk. An appropriate risk mitigation plan was in place to minimise the risk of harm to children and young people. This included; prioritising surgery based on clinical need, reviewing children and young people for harm whilst waiting for surgery, training ward staff in theatre competencies and working with other providers to share best practice with methods to increase surgical activity during restoration of services post Covid.

Risk register entries showed that most entries had been reviewed over time. However, the register did not record planned review dates to ensure risks were consistently reviewed over time in accordance with the trust's risk management policy.

Surgery

Minutes of committee and board meetings showed that the highest level of risks within the service were discussed on a regular basis which showed there was senior management and board level oversight of extreme risks.

Mortality and morbidity reviews were regularly completed to review and learn from deaths and other adverse incidents. Staff told us learning was shared from these meetings to ensure learning was shared.

A monthly quality performance report was produced. Items covered included; complaints, incidents, safeguarding and risk. Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division.

Managers monitored staffs' compliance with training and they were aware of gaps in training compliance rates. Where gaps were identified, appropriate action was taken to address these.

Managers told us that individual staff performance issues were addressed in line with the trust's performance and disciplinary policies and procedures. This included where necessary suspending staff and making referral to professional bodies, such as the Nursing and Midwifery Council.

Information Management

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

The trust's website assisted children, young people and their families to familiarise themselves with the services offered and what to expect during an admission.

Information technology systems were used to monitor and improve patient care. A wide range of information was available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances.

Service performance measures were reported and monitored. Manager's and senior staff had access to these reports and relevant and appropriate service performance information was displayed on boards within the service so that staff and visitors could see at a glance how well the service was performing.

The service shared data securely with us and other agencies in accordance with legislation. For example, serious reportable incidents were reported to us and the National Reporting and Learning System (NRLS) as required.

The service had a business continuity plan which provided guidance on maintaining services and dealing with business interruptions which might disable services or require special arrangements to be put in place to allow them to continue, for example a cyber-attack.

The service was working towards introducing electronic records and electronic prescribing.

Engagement

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

Surgery

Managers and staff actively engaged with children and young people to enable them to plan and manage the service. The service had an active young person's advisory group in place. This was made up of young people aged 11 to 19, patients, ex-patients, siblings and interested members of the local community. This group was used by the service for multiple tasks, including; quality improvement projects, recruitment and the monitoring of quality. For example, the group had been consulted and involved with the design of artwork around the day surgery area. This ensured the artwork was relevant to young people as well as children who used the service.

Managers and staff were in the process of forming a virtual family and patient advisory council with the aim of improving services, introducing new initiatives and modernising services.

Managers told us how they had used patient feedback forums to test a digital collection tool which they were due to pilot. The aim of this tool was to help to improve preadmission processes ensuring children and young people get the right pre-admission assessment based on the information they provide.

The trust worked effectively with other local and national organisations within the local and wider integrated care systems. This included, other NHS trusts, local authorities, Healthwatch, primary care services and charities. For example, we saw how managers had worked with various stakeholders within the integrated care system with regards to access to children's eye care. Task and finish groups were then formed to use the information from stakeholders with the aim of improving access to children's eye care.

Managers and staff worked to raise awareness and address equality concerns. For example, in a response to an idea from a consultant surgeon about the need to raise awareness around the need for accessible fashion. Managers and staff had worked with children, young people and students from a local college to successfully collaborate in the planning and participation of a fashion show featuring children and young people who used the service.

Learning, continuous improvement and innovation

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

Innovation was encouraged at all levels. Staff within the surgical service used the trust's quality improvement training to improve quality and experiences for patients and staff. For example, staff from ward 10 introduced a buddy system for newly qualified nurses on the ward. Ward staff had identified that it could be daunting coming into a new environment and sometimes newly qualified staff could find it difficult to share with others with regards to how they were feeling. The buddy system was successfully trialled and introduced on the ward. Nurses who have completed their post qualification preceptorship period provide buddy support to newly qualified nurses.

Theatre staff and surgeons were trialling and implementing High Intensity Throughput Theatre (HITT) lists to aid recovery of surgical referral to treatment times post pandemic. A HITT trail in Urology showed that theatre utilisation increased from 40%-54% to 74% and 86%. Managers were learning from the successful introduction of HIIT lists and were applying learning to other clinical specialties or theatres.

New technologies were being used to improve care pathways and patient experience. For example, a digital referral, advice and triaging app had been successfully introduced with the service for hand trauma. This had been time saving for referring and reviewing clinicians and had improved patient pathways.

Surgery

Innovative surgical procedures were developed at the service. For example, this service was the only service in the UK offering augmented reality paediatric surgery for tumour resection and bowel surgery. Augmented reality surgery involves using a fluorescent dye and near infrared cameras to be able to give a different view during surgery. Using this technique gave children and young people better surgical outcomes.

Staff participated in local, national and international research and shared research outcomes through posters, conferences and journal publications. Staff showed us examples of publications from journals including the Royal College of Surgeons of England Journal and Journal of Paediatric Surgery.

Child and adolescent mental health wards

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff had not always completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We identified various blind spots that had not been mitigated on Ashfield Ward. These had not been included on the providers environmental risk assessments.

Staff could not observe children and young people in all parts of the wards. There were areas of Ashfield Ward that could not always be observed by staff. Due to the design of the ward, we found that there were several areas which could not be easily observed from the main ward area such as corridors that led to offices and the extra care suite. Following our inspection, we requested immediate assurances from the trust that they were taking action with regards to these blind spots. We revisited the service between 10 and 11 October 2022 and found that Ashfield ward had been closed and patients moved to other, more suitable, accommodation.

The wards we visited were both mixed gender and the ward did not comply with guidance on mixed gender accommodation. Neither ward had a designated sitting room specifically for females to use exclusively as per guidance on mixed gender accommodation

We did not see any potential ligature anchor points in the service that had not been mitigated. Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe.

We found that staff did not always have access to alarms. Due to high staffing numbers, there were not always enough alarms for the number of staff on duty. We were told at the time of our inspection that new alarms were on order and they were awaiting delivery. There was no patient nurse call system in place. This was mitigated by staff presence in bedroom corridors at night.

Maintenance, cleanliness and infection control

During our inspection the ward area on Irwin Ward was clean, well maintained, well-furnished and fit for purpose. However, on Ashfield ward we found that there were several areas that were not clean or well maintained. There was a shower room that was out of use due to water damage to the floor. This was creating a strong smell of damp that was encroaching into other areas of the ward. The small practice kitchen on the ward was visibly dirty. Floor and work surfaces had not been cleaned and there was food residue in cupboards and drawers. We immediately requested that this area be taken out of use until a deep clean could be arranged. Managers worked quickly to arrange this, and the area was clean and fit for purpose by the time we left the unit.

Staff did not consistently follow infection control policy, including handwashing. We observed staff using hand washing stations and we were encouraged to use hand sanitiser upon entry and exit of all areas of the unit. Masks were being worn in clinical areas or at any time when there was patient contact. We observed that all staff were using masks in these areas, but we did observe poor practice where some staff were removing their masks in ward offices or wearing them incorrectly in ward areas. We also observed some staff that were not following infection control guidance around being bare below the elbow. Some staff were wearing watches or jewellery that did not comply with guidance. Following our inspection, we requested immediate assurances from the trust to take action with regards to cleanliness, maintenance and infection control measures. We revisited the service between 10 and 11 October 2022 and found that Ashfield ward had been closed and patients moved to other, more suitable, accommodation.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff cleaned equipment but we found that not all equipment had check or calibration stickers attached as required.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe. We found that all shifts were covered in the two months prior to our inspection using a combination of full-time staff, bank staff that were drawn from their full-time staff group as an alternative to working overtime or experienced agency staff. Where possible the unit used agency staff that were familiar with the unit and had worked with the children and young people before

Managers limited their use of bank and agency staff and requested staff familiar with the service. Bank staff were drawn from the existing staff group who worked bank shifts as an alternative to working overtime.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. New staff had an orientation period with an experienced member of staff and a specific extended handover to give them more information about the children and young people on the ward.

The service had low turnover rates and levels of sickness were reducing.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Basic staffing levels for each ward were set by using a trust wide tool. If staff were required above these numbers, ward managers or the nurse in charge could make the decision and bring in more staff without first seeking approval from senior managers.

Children and young people had regular one to one sessions with their named nurse. We saw high levels of interaction between staff and patients and all patients we interviewed told us that they knew who their named nurse was. They also told us that they could always have one to one time with them.

Children and young people rarely had their escorted leave cancelled, even when the service was short staffed. We were told by several staff and patients that sessions were occasionally cancelled due to the pressure on staff.

The service had enough staff on each shift to carry out any physical interventions safely. The staff rotas showed us that there were always enough staff on the wards to ensure that this was the case.

Staff shared key information to keep children and young people safe when handing over their care to others. We observed a handover meeting and a multidisciplinary team meeting and saw that key information was shared in a way that was clear and understandable.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Throughout the day there was a consultant and two doctors on site Monday to Friday. Out of hours and at weekends the hospital ran an on-call rota for medical staff to ensure that there was always a doctor available.

Managers could call locums when they needed additional medical cover. We spoke with the consultant who informed us that he could make the decision to call a locum for cover if required.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory training rates were on average above 90% for both wards. There were some training courses that had been affected by a lack of available spaces and compliance rates for these were lower. The courses that were mostly affected involved face to face training sessions such as prevention and management of violence and aggression, basic life support and intermediate life support. There were plans in place to address this shortfall and extra training sessions had been booked. Compliance remained above 75% for these courses.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included subjects that were specific to working with children and young people. This included safeguarding children and sessions that focussed on capacity and consent in children's services including a session on Gillick Competence and the Fraser Guidance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to staff training records and planned their rotas to include time for staff to complete mandatory training.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We found that, in all records we checked, a Galatean Risk and Safety Technology (GRiST) risk assessment had been undertaken. This was a recognised risk assessment tool that is appropriate for the area it was being used. However, we found that in two of the records we checked on Ashfield ward they were not always fully filled in. Notes that we checked also contained specific risk assessments where required, for example to assess the risk of physical health issues.

Child and adolescent mental health wards

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff we spoke with had good knowledge of all the young people they were looking after and could talk us through specific risks and treatment plans

Staff identified and responded to any changes in risks to, or posed by, children and young people. We noted that risk was regularly reviewed at multi-disciplinary team meetings and risk assessments had been updated quickly where risks had changed.

Staff could not observe children and young people in all areas, but staff followed procedures to minimise risks where they could not easily observe children and young people.

Staff followed trust policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. All the children and young people's records we reviewed during inspection contained a positive behaviour support plan that had been created in collaboration with the individual. These contained information about effective de-escalation strategies and things to attempt before physical interventions were used.

Staff understood the Mental Capacity Act definition of restraint and worked within it. The training that staff received in managing challenging or aggressive behaviour contained theory sessions that covered the legal frameworks under which restraint and physical interventions could be used.

Staff followed NICE guidance when using rapid tranquilisation.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation. Both wards had extra care areas where a child or young person could be nursed in isolation. One of these was in use during our visit and we noted that care was being delivered in line with the organisations policy on nursing in long term segregation.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Full time staff received safeguarding training to level 2. Identified staff on each ward had received safeguarding training to level three and were the wards safeguarding leads.

Staff kept up to date with their safeguarding training.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. There were several children and young people on both wards who had protected characteristics and staff could talk us through the specifics of care plans relating to this.

Staff knew how to recognise children at risk of or suffering harm and worked with other agencies to protect them. The hospital had close links with local authority safeguarding teams. Also, an independent advocate visited both wards regularly.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with had completed their safeguarding training as part of their annual mandatory training and could identify the wards safeguarding lead.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were not always comprehensive, but all staff could access the notes easily. The unit used paper notes. However, we found that in three out of the nine sets of notes that we checked sections had not been completed and information was missing. They were stored securely and all staff that needed to access them could. Due to the lack of an electronic record, staff could not easily access information that had been included from other teams within the trust.

When children and young people transferred to a new team, there were no delays in staff accessing their records. When patients transferred to a new team within the trust, a copy of their care notes went with them.

Records were stored securely. Records were stored in lockable cabinets in the nursing offices.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. These processes were in line with national guidance. A local pharmacy undertook a weekly audit of prescribing and administering medication

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. Medication was reviewed at regular multi-disciplinary team meetings.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. On the inspection we identified that the medication cards that the service was using were in line with trust policy but were not appropriate for use in this service. Because they were standard medication cards used in paediatric services, they did not contain mental health information on the front of the card. This meant that staff could not readily see the legal status of the young person. We pointed this out at the time of our inspection and the service added a front sheet to medication cards immediately. We were told by senior managers that an immediate review had been undertaken and new medication cards specific to mental health services were on order.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. The clinics had notice boards where any alerts could be posted. Incidents and reviews were discussed at regular staff meetings and handovers

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The wards held regular weekly multi-disciplinary team meetings where medication was discussed for each patient.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance. Each young person had a physical health care plan in place in the notes that we checked. Physical health was monitored regularly as part of this plan.

Track record on safety

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff recognised incidents and reported them appropriately. However, managers did not investigate incidents or share lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. We looked at incident reports and found that incidents were recorded appropriately on the incident recording system. Staff we spoke to told us that they knew how to report incidents and could use the systems.

Staff reported serious incidents clearly and in line with trust policy. The service had no never events on any wards.

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

Managers debriefed and supported staff after any serious incident.

However, managers did not investigate incidents thoroughly. Between 27 March and 21 June 2022 there were 323 incidents reported across the two wards which consisted of 197 on Ashfield ward and 126 on Irwin ward. Of the 197 on Ashfield ward only 34 had been reviewed and closed within the Trust's three-month time period. This meant 80% of incidents had not received a review, including 24 incidents in which harm had been identified. This meant impact had not been considered and any lessons learned had not been identified or shared. On Irwin ward we found that whilst most incidents had been reviewed and closed, we could not see that where incidents related to risks of harm to children and young people that there had been any update to individual risk assessments.

It was not always clear that children, young people and their families were involved in these investigations.

There was some evidence that changes had been made as a result of feedback. We saw new systems in place on Ashfield ward for managing access to hot drinks as a result of reviews following an incident. There were new working practices in place to support young people after meals as a result of reviews undertaken after incidents. Staff received feedback from investigation of some incidents, both internal and external to the service. However, this was not always in a timely manner due to the delay in managers reviewing incidents.

Following our inspection, we requested immediate assurances from the trust to ensure that they were taking action with regards to incident management.

Child and adolescent mental health wards

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. We saw that there were mental health assessments undertaken at or soon after admission in all the care records we checked.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A physical health assessment was undertaken as part of the admission risk assessment and, in cases where ongoing monitoring of a physical health condition was required, there was evidence in the care notes we checked that this was being undertaken.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. Each care record we looked at contained a comprehensive package of care plans that covered both mental and physical health needs.

Staff regularly reviewed and updated care plans when children and young people's needs changed. We saw that care plans had been reviewed and updated at regular multi-disciplinary team meetings. We also attended a multi-disciplinary team meeting where individual care plans were discussed.

Care plans were personalised, holistic and recovery orientated. Young people had been involved in the creation of their care plans in collaboration with nursing staff. In cases where young people refused or were unable to give feedback into their care plans this was clearly documented.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the children and young people in the service. These included cognitive behavioural therapy, and dialectic behavioural therapy.

Staff delivered care in line with best practice and national guidance. Care was delivered in line with guidance issued by the National Institute for Health and Care Excellence.

Staff made sure children and young people had access to physical health care, including specialists as required. We saw evidence in patients notes that young people attended hospital or G.P. appointments as required.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. We saw that patients were supported with dietary intake on both wards but particularly on Irwin ward which was a specific eating disorder service. There were fluid and nutrition monitoring charts in place and young people, who required them, had support plans in place around mealtimes.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. We saw that staff encouraged young people to take part in programmes that were offered which included therapy and education.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. These included the Management of Really Sick Patients with Anorexia Nervosa (MaRSiPAN) checklist which is a tool specific to working with people with an eating disorder.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of children and young people on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the children and young people on the ward. At the time of our inspection the service had allocation for a dietician for half a day a week. The dietician had recently left, and this post was vacant. Cover was being provided from other dieticians within the trust.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. There was a complete mandatory training programme in place for staff. The service did not generally use agency staff as part of the ward team, but where they were used to cover long term sickness, they attended training within the trust. Bank staff were all drawn from current members of staff which meant that their training and development could be monitored. During our inspection agency staff were being used to manage a young person in long term segregation who had specific needs. Staff working with them had recieved specific training from the agency and compliance with this training was being monitored by the trust.

Managers gave each new member of staff a full induction to the service before they started work. The service had a new starters' checklist in place that all new starters were expected to complete with their managers. This meant that new starter development could be monitored. All new starters attended staff induction prior to starting on the ward.

Managers supported staff through regular, constructive appraisals of their work. Staff appraisals were above 95% on both wards.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Staff received clinical supervision every 4 weeks, although we were told by staff that it wasn't always possible to take the time away from their role due to how busy they were.

Managers supported medical staff through regular, constructive clinical supervision of their work. All medical staff we spoke with told us that they recieved regular clinical supervision in line with their role.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings occurred on the wards every month and staff who could not attend were updated on any actions at handover or directly via one to ones.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw that staff had personal development plans. We were also told by staff that they had attended development training specific to their role.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. We observed one of these meetings and found that discussions were complete, included everything that needed to be discussed and involved input from the young people being discussed.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. We observed one handover meeting and looked at several handover records and found that all information that needed to be discussed was. There was a full discussion about each young person which included setting out any expectations for the day. This included discussions about leave and any associated impact factors.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Ward managers acted as mental health act leads to give support and advice to staff. The hospital also had Mental Health Act administrators who managed any documentation relating to the act and could support ward staff.

Staff we spoke to knew who their Mental Health Act administrators were and when to ask them for support.

Child and adolescent mental health wards

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. There were policies available on the wards in paper format that were updated as and when required.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. An independent mental health advocate visited the wards weekly and was available to meet with young people.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time. Young peoples' records showed that their rights had been explained to them and there had been a discussion with the young person at admission or as soon as possible afterwards. There was evidence in care records that this process had been repeated if required. Children and young people we spoke to told us that they had had their rights explained to them and that they understood them.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. We saw young people taking section 17 leave and saw that it was written up in young people's care records.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed. All paperwork relating to the act was kept in its own section in the young peoples' care records. It was clearly marked and easy to find in the record.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Part of this training was specific to working with children and young people.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Child and adolescent mental health wards

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision. Capacity to consent was clearly recorded in all the care records we checked and in cases where a capacity assessment had been required, this was also recorded.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. We did not see any applications for Deprivation of Liberty Safeguards while we were on site.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people. We observed high levels of staff and young person interactions during our inspection. Staff were available to young people on the ward whenever they needed them, and staff treated young people with dignity and respect.

Staff gave children and young people help, emotional support and advice when they needed it. We observed that staff had developed good working relationships with the young people and could engage them in emotional support and advice.

Staff supported children and young people to understand and manage their own care treatment or condition. Key worker discussions were noted in the patient records which showed that staff had engaged young people so that they had developed an understanding of their care

Staff directed children and young people to other services and supported them to access those services if they needed help. An independent advocate attended the service weekly and we saw that staff had directed young people to speak with them.

Child and adolescent mental health wards

Children and young people said staff treated them well and behaved kindly. We received positive feedback from the young people we spoke with who stated that they felt that they were treated well by staff and found them supportive. Some young people felt that agency staff were not as supportive as full-time staff as they did not spend as much time with them.

Staff understood and respected the individual needs of each child or young person. During our inspection, staff were able to talk us through individual care packages and explain how these had been tailored to a young persons' needs. They showed good knowledge of their patients and an understanding of what they required from their care.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. Staff we interviewed told us that they felt they could raise problems or concerns with managers and felt that, if they needed to, they would be listened to and managers would take action to address these concerns.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates and to child helplines.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. Every young person had a ward orientation session upon admission where they were shown around the ward and introduced to the other young people on the ward. They were also given a welcome pack that contained relevant information about the service.

Staff involved children and young people and gave them access to their care planning and risk assessments. We were told by the young people we interviewed that they had been offered copies of their care plans and risk assessments and that they had been helped to understand their care by staff. We were also told that young people were confident that staff would answer any of their questions about their care.

Children and young people could give feedback on the service and their treatment and staff supported them to do this.

Staff supported children and young people to make decisions on their care. We noted that care records we checked had been created in collaboration with the young person. In cases where the young person had been unable or refused to be involved in their care planning this was clearly noted.

Staff made sure children and young people could access advocacy services. Information about advocacy services were clearly posted around the unit and an independent advocate attended the unit weekly.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers we spoke to told us that they felt included in the care of loved ones and that staff would communicate any changes to care quickly. The stated that they felt involved in care and were invited to attend meetings where there were discussions about a young person's care.

Child and adolescent mental health wards

Staff helped families to give feedback on the service. Carers told us that they felt that they could ask questions or raise concerns about the service. They told us that, if they needed to raise concerns, they were confident that staff would listen to them and act on their concerns.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. We observed a multidisciplinary team meeting where length of stay was discussed and saw that admission information was contained in the front of young people's notes to ensure that length of stay could be monitored easily.

The service had no out-of-area placements.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

When children and young people went on leave there was always a bed available when they returned. A young person's bed was assigned for the entire length of their stay and would not be used to admit another patient during any period of leave.

Children and young people were not moved between wards during their stay as the two wards had different admission criteria. Irwin ward treated children and young people with eating disorders and Ashfield ward was an assessment and treatment ward for children and young people with a range of mental health difficulties.

Staff did not move or discharge children and young people at night or very early in the morning. Discharges only happened during the hours of nine to five Monday to Friday.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. We saw two cases where discharge had been delayed due to difficulty finding a bed in an appropriate unit for the young person to move to. These were being monitored by managers and staff were working with outside agencies and local authorities to resolve both cases. At the time of our inspection placements had been identified for both patients and referral work was being undertaken.

Children and young people did not have to stay in hospital when they were well enough to leave.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. We spoke with staff and young people who were close to discharge and looked at young people's notes. We found that the young person had been involved in their discharge planning and knew what was happening and staff had completed all paperwork and liaised with external bodies in line with the trusts policies.

Staff supported children and young people when they were referred or transferred between services. We observed staff supporting a young person on Ashfield ward who was preparing to transfer between services by visiting the unit they would be moving to. They were supportive and had explained what would happen in detail to reduce levels of anxiety about the move.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people could make hot drinks and snacks at any time.

Each child or young person had their own bedroom, which they could personalise. We looked at several patients bedrooms during our inspection and saw that they had been personalised with posters, photographs and the young person's own property.

Children and young people had a secure place to store personal possessions. All bedrooms we looked at had a lockable cupboard and all young people were assigned a locker on the ward where they could store items.

Staff used a full range of rooms and equipment to support treatment and care. Both Ashfield and Irwin wards had rooms on the ward that staff could use to support treatment and care. These included rooms that were set aside for education and occupational therapy activities if young people could not leave the ward. There was also a building on site dedicated to education activities that had many rooms that were dedicated to different activities. This included classrooms, a sports hall gym area and rooms set aside for arts and crafts.

The service had quiet areas and a room where children and young people could meet with visitors in private. Both ward areas had quiet rooms set aside that young people could use if they wanted time away from the main ward area. There were also rooms set aside on both wards where young people could meet with visitors. We also saw that young people were encouraged to use the grounds areas to meet with families if they had the correct level of unescorted leave.

The service had an outside space that children and young people could access easily.

Children and young people could make phone calls in private.

and could make their own hot drinks and snacks and were not dependent on staff. Young people had access to their own mobile phones which they could use in the privacy of their own bedrooms or in quiet rooms. If young people did not have their own phones or access to their phones were restricted due to identified individual risk factors, young people could access ward telephones in a private area.

The service offered a variety of good quality food. All food was prepared on site by catering staff. We were told by young people we spoke to that the food was of good quality and though there was a set menu, this was reviewed regularly and there was always a choice of meals each day.

Child and adolescent mental health wards

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education and work and supported them. Young people were offered a full range of education opportunities on site delivered by qualified teachers. This meant that young people could continue their formal education during their admission. The education department offered a wide range of lessons and courses where young people could work towards formal qualifications that mirrored what would be available in a mainstream school.

Staff helped children and young people to stay in contact with families and carers. We were told by young people and carers that staff had encouraged young people to maintain relationships with family members and friends during their admission and had facilitated visits and regular calls to assist in this.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The unit had disabled access and all documentation and signage posted around the building was in an accessible format. We were also told by staff at the unit that easy read documentation was available if required.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. Young people were given a welcome pack on admission that contained information on treatment, support services and local services. The pack also contained information about how a young person could access advocacy services. This information was also posted around the unit on notice boards.

We were told by staff and managers that information leaflets could be made available in languages spoken by children, young people and the local community if requested.

Managers made sure staff, children and young people could get help from interpreters or signers when needed. The trust had a contract with interpreter services, which included access to signers, if required.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. This included food that was sourced and prepared in line with cultural or religious requirements.

Children and young people had access to spiritual, religious and cultural support. There were multifaith rooms available for young people who wanted to use them. Local religious leaders were available if required and could visit the unit to provide guidance and religious support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Child and adolescent mental health wards

Children, young people, relatives and carers knew how to complain or raise concerns. All young people and carers we spoke to stated that they knew how to make a complaint and felt confident that they would be supported by staff if they needed to complain.

The service clearly displayed information about how to raise a concern in patient areas on notice boards. This included direction on how young people could access support from an external advocate.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they had received training in handling complaints and could talk us through the complaints procedures.

Managers investigated complaints and identified themes. We reviewed several complaints as part of our inspection and found that they had been investigated and, if they had been upheld, appropriate action had been taken to address concerns.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Information was shared at regular staff meetings, at handovers or one to one if required.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

Leaders had the skills knowledge and experience to undertake their roles. Senior managers had been recruited with experience of similar units and ward mangers had received training in leadership and management.

Leaders had a good understanding of the services they managed. They could clearly explain how the teams they managed were working to provide care.

Leaders were visible in the service. Staff told us that there had been improvements in the engagement from senior leaders in the twelve months prior to our inspection. We found that new senior leaders had been appointed since our last inspection and work had been undertaken to engage staff.

Leadership development opportunities were available. This included all staff including staff below manager level.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The providers senior leadership team had successfully communicated the providers visions and values to staff in front line services

Staff had the opportunity to contribute to discussions about the strategy for the service.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us they felt respected, supported and valued. They told us they felt positive and proud to be working as part of the service. Staff felt able to raise concerns without fear of retribution and staff we spoke to know how to use the whistle blowing procedure and about the role of the freedom to speak up guardian. Staff worked well together. We saw high levels of interactions between staff and team meetings were undertaken in a way that included everyone who was attending.

Staff appraisals included a conversation about personal development and how it could be supported. Staff reported to us that the provider supported and promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff sickness and absence rates were in line with trust set targets, and staff had support for their own physical and emotional health through an occupational health service.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

We found issues with medication cards and clinical notes which audit processes in place were ineffective in highlighting.

On Ashfield ward we found that there was a lack of system in place to ensure staff were adhering to infection control measures including mask wearing and also found that the ward was visibly unclean, with a smell of damp and evident water damage to some areas. Whilst managers took action to rectify these concerns whilst we were on site there was no process in place to ensure oversight and action of such concerns. We also found blinds spots on Ashfield ward where children and young people could not be observed, and managers were not aware and had not effectively mitigated these concerns.

We also found that many incident reports had not been investigated or actioned within the Trust's timeframe and managers did not appear to have effective oversight of this. This included 80% of incidents between 27 March and 21 June 2022 on Ashfield ward which had not been reviewed. We were concerned that this meant learning from incidents was not being identified or subsequently shared with staff.

Child and adolescent mental health wards

Following our inspection, we requested immediate assurance from the trust that improvements be made with regards infection control and incident management and the trust responded to this with an immediate plan of action. We revisited the service between 10 and 11 October 2022 and found that Ashfield ward had been closed and patients moved to other, more suitable, accommodation; mitigating the issues found with regards infection control, blind spots and environment. The trust also provided evidence to demonstrate that all outstanding incidents had been reviewed and had put in place a system to ensure incidents were reviewed in a timely manner, as per the trust's incident management policy, going forwards.

Management of risk, issues and performance

Teams had access to most of the information they needed to provide safe and effective care but did not always use that information to good effect.

Staff maintained and had access to a risk register at a team level and could escalate concerns when required. Staff concerns around staffing levels and the environmental challenges faced by Ashfield ward matched items on the risk register. However, managers had not taken timely action to mitigate these risks, for example environmental challenges had not been addressed until inspectors raised concerns.

Staff were not always fully completing patient records to ensure patient information was up to date. We found that in three out of the nine sets of notes that we checked sections had not been completed and information was missing.

The service had contingency plans in place, such as for adverse weather or a flu outbreak.

Information management

Staff engaged actively in local and national quality improvement activities.

Though the wards were still using paper records, the collection of data was not overburdensome for staff.

Staff had access to equipment they needed to undertake their work.

Information governance systems included maintaining the confidentiality of young peoples' records.

Managers had access to information to support them in their management role. This included information about the performance of services, staffing, staff training and the care of the young people.

Staff made notifications to external bodies including local authorities, commissioners and the care quality commission when required.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, young people and carers had up to date information about the work of the provider and the services they used through regular engagement meetings and bulletins.

Young people and carers had the opportunity to give feedback on the service.

Child and adolescent mental health wards

Managers and staff had access to feedback from people who use the service and used it to make improvements.

Young people and staff had the opportunity to meet with senior leaders to give feedback.

Directorate leaders engaged with external stakeholders such as commissioners and Healthwatch.