This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Birmingham Community Healthcare NHS Foundation Trust (BCHC), delivers community-based healthcare services to the 1.1 million residents of Birmingham and universal and specialist services to the 5.5 million people within the wider West Midlands region.

The trust had an annual turnover of £275 million in 2016-17. They employ more than 4,200 whole time equivalent staff and delivered 2.1 million patient interactions in the last financial year.

The trust achieved foundation trust status in 2016.

The services which covered approximately one million people were delivered in people’s homes and clinics, as well as at 12 primary care sites. These were:

- Moseley Hall Hospital
- West Heath Hospital
- Ann Marie Howes Centre
- Birmingham Community Healthcare NHS Foundation Trust headquarters
- Birmingham Dental Hospital and School of Dentistry
- Community Unit 27
- Edgewood Road Children’s Centre
- Kingswood Drive
- Perry Tree Centre
• Riverside Lodge
• The Bungalow, Hobmoor Road

Core services delivered include:
• Community health services for adults
• Community health services for children and young people
• Community health inpatient services
• Community end of life care
• Secondary care and community dental services
• Learning disability services

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

The trust had five divisions:
1. Children and Families
2. Adult and Specialist Rehabilitation
3. Adults Community Services
4. Dental Services
5. Learning Disability

The divisions reported into the following departmental structure:

(Source: Trust data return DR116)
Previous CQC inspections

The trust was last inspected in June 2014 and the report was published in September 2014. We found that the trust was performing at a level which led to a judgement of Good. Services were deemed to be safe, staff reported incidents and near misses and learning took place. The majority of services had sufficient staff. There were a number of vacancies across most teams, especially administrative staff, which were impacting on the delivery of services. Staff received suitable training and supervision.

Services were delivered using evidence based practice, and were delivered through multidisciplinary teams utilising care pathways. The majority of premises were fit for purpose and equipment was available for staff to access in the community.

Staff were caring and compassionate, and we saw some excellent examples of care especially in end of life services. The majority of services were responsive to the needs of patients, and there were innovative examples of care delivery. However, there were some services, particularly in dental and children and family services where services were not as responsive as they should be.

The trust was considered to be well led, with an accessible and visible executive team, especially the chief executive and executive nurse. Governance systems and processes are in place and there is performance and quality management information available. Quality was high on the trusts agenda.

Overall the trust was rated good for each service.

Financial position

The trust’s annual report for 2017/18 described the year as being both hugely challenging and enormously rewarding. The report further stated that the trust had achieved their main performance and financial targets.

The trust has a strong financial position and has achieved surplus positions over the last 4 years and is on track to achieve a £4.1m surplus in 2018/19.

In 2015/16 the trust reported a surplus of £2.1m less than planned due to charges for impairments related to the new Dental Hospital. Several capital schemes were undertaken and were broadly categorised as £2.4m for the new Dental Hospital, £3.0m for buildings (including maintenance) and £2.3m for IT related issues.

In 2016/17 the trust reported a year end deficit of £1.074m which was a technical deficit after adjusting for charges for impairments (£5.8m) less additional STF monies (£836k) and proceeds on sale of assets (£21k). Capital schemes broadly categorised as £5.1m buildings (including maintenance), £2.5m IT related and £0.5m other equipment.

In 2017/18 the trust had a planned surplus of £4.8m which at the time of the inspection was set to be over-achieved by £460k due to a profit on sale of two fixed assets.

The trust had a financial plan in place for 2018/19. Due to the delay in the publication of annual planning guidance by NHS Improvement and NHS England for 2018/19, the final plan for next financial year had not been finalised at the time of the inspection.

The trust held a variety of contracts across the CCG, NHS partners, specialist contracts and the local authority. Some of the contracts were long term and were assured for the future. Others were either due to come to an end or were in the process of re-negotiations.

In 2017/18 the trust was in the process of acquiring two local mental health trusts known as the Transforming Care Together (TCT) programme. However, after a lengthy due diligence process the trust made the recommendation to stand down the TCT programme and all associated acquisition plans.
Cash releasing efficiency savings (CRES) identification was driven by the divisions with clinical input. Each saving scheme was specified and scoped by the Divisional Team proposing. This created a direct link between the individuals leading the service or delivering care. Each CRES moved through a two stage ‘gateway’ process to ensure there are fully developed project initiation documents (PID) that were monitored to ensure successful delivery. The trust has a good track record of delivery its CRES programme.

The individual CRES schemes are reported on monthly and discussed at Performance and Programmes Management Board (PPMB), where all aspects of CRES delivery are monitored collectively including; financial; milestones delivery; quality indicator metrics; benefits and risks. By reporting the performance across all domains of a CRES project in one document with clear metrics, triangulation of data is possible and assurance on all aspects of CRES delivery is provided.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£260.9m</td>
<td>£275m</td>
<td>£269.2m</td>
<td>£276.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£1.5)</td>
<td>(£1.1m)</td>
<td>£5.3m</td>
<td>£4.4m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£259.4m</td>
<td>£276.1m</td>
<td>£264m</td>
<td>£272.4m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£3.6m</td>
<td>£3.9m</td>
<td>£4.8m</td>
<td>£4.4m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P69 Finances and trust data return DR155)

What people who use the trust’s services say

In April 2018, a total of 1764 patients participated in patient surveys (including the friends and family test) FFT. Of the 1764 responses, 94% of patients said they were extremely likely or likely to recommend the trust’s services to someone else. In the 12 months prior to our inspection we saw that over 90% of respondents were consistently satisfied with the services they accessed within the trust.

FFT scores for the year January – December 2017 ranged from 90 – 97 and satisfaction rating (excellent or very good scores responses only) was between 90% and 96%.

The trust undertook a number of engagement activities in 2017/18. These included a Specialist Service focus group for the Birmingham Wheelchair Service where patients and carers who accessed the service worked with clinicians to look at communication and on-going user involvement. The Public Engagement Manager supported clinical teams in the Learning Disability Services around the relocation of services.

Is this organisation well-led?

Leadership

Although leaders possessed the skills and knowledge to lead the trust, they were not always aware of the risks, issues and challenges across trust services. There was an over reliance on divisional leadership and quality oversight with little or no quality sampling or
robust assurance. The trust executive team generally did not have robust oversight of the key risks affecting the divisions.

There had been some changes to personnel and roles taking place since our last inspection in 2014. The chief executive joined the trust in March 2018. The most recent member to the executive team was the interim director of corporate governance, who took up post in April 2018.

The executive directors had the skills, knowledge and experience to lead the trust. Ongoing improvements were a continued focus for the executive team, such as the refresh of the trust strategy, visions and values. Board members explained a comprehensive board development programme in support of embedding the executive team.

The chief executive, director of nursing and therapies, medical director, chief operating officer and chief financial officer all had deputies who could act up in their absence. These deputies held positions in the senior leadership teams and had the relevant clinical and managerial experience and skills required to act up into the roles.

However, we found there had been a lack of capacity amongst the executive directors. Executive team members had faced challenges because they had been drawn into operational issues within the organisation due to the proposed acquisition.

To address challenges to quality and safety, the trust leadership team commissioned external reviews. We saw many examples of when this had been the case. One example was a review of the board effectiveness, governance and risk reviews which was in the process of being completed during inspection. The trust had also requested an external review of its never events within the dental service.

The trust had recently introduced a five-division structure supported by triumvirate management structures, each setting key areas of responsibilities and accountabilities. However, these were not always effective. An example of this was the lack of oversight and flow of known staffing risks within the children and families’ division. The breakdown resulted in the lack of visibility of the scale of the issues at board level.

Local service level leadership was provided by matrons and ward managers. We met with some committed divisional senior leaders who demonstrated comprehensive understanding of their departmental issues, with the drive, knowledge and tenacity to deliver high quality care.

We did however see that there was a lack of capacity amongst the leadership teams to be able to drive improvement at pace. We did not see evidence of any risk(s) being identified by the impact of the new divisions within the corporate risk register or board assurance framework.

There were regular board development days that took place to ensure that individual and organisational skills were developed. A recent board workshop had focused on the staff survey results with a view to securing improvements. There was a recognition that more work needed to be done on equality, staff engagement and widening the demonstration of the values. The board also recognised that development was needed to ensure messages from front line services were identified, heard and addressed via effective governance and staff engagement.

The board had commissioned an external review to support the board development agenda, with a focus across the following areas:

- level of scrutiny and challenge
- board reporting
- the balance of the Board’s understanding of clinical/quality/commercial issues
- decision-making
- individual effectiveness of board members
- chairing and functioning of Board and Board Committees

Alongside board development plans, the portfolios held by the board and governance structure were also being considered. The board considered the commencement of the new chief executive as a time appropriate opportunity to review and develop the current efficiencies and structure.

The board had plans in place to develop and improve leadership at all levels. Actions in place included leadership and talent are included being included in the Organisational Development Strategy Implementation Plan (2017 - 2018). This strategy had 10 core objectives; three of which directly related to aspects of leadership development.

- Objective 3. Increasing leadership capacity through effective ways of working

- Objective 4. Embedding effective systems leadership approaches

- Objective 5. Improving generic leadership capacity

The trust also had a number of internal leadership programmes which had all been refreshed in the last two years. The trust told us that the take up of both internal programmes was high and the trust expected this to remain to be the case.

Between April 2016 and December 2017, the following numbers of staff completed the below non-accredited programmes:

Senior Leadership Development Programme – 38 staff

Inspire Leadership Programme – 64 staff

ILM accredited qualification programmes – 32 staff

The trust told us there had also been a further 32 staff who have attended ILM accredited qualification programmes

Whilst the trust leadership team had knowledge of the current priorities and strategic challenges, they were not sighted on significant issues and risks at divisional and service level. An example of this was in relation to concerns found in the children and families' division such as high caseloads, missed antenatal contacts and staff and trust adherence to lone working policy.

When we raised these issues, the trust responded urgently with action plans to address these concerns. However, staff told us and we saw evidence that these issues had been present for some time prior to the inspection. Although staff retention and recruitment was referenced on the board assurance framework, there was no specific reference to the very serious issues in the children's and families' division. This was also not referenced in the private board minutes reviewed.

The executive team made efforts to ensure they were visible to staff working in frontline services. This included planned and unplanned visits to clinical areas to observe and engage with staff. In 2017 the chief operating officer made 12 visits to clinical areas, the director of nursing and medical director also undertook four visits in this period. Most staff we spoke with welcomed these visits.

Staff told us of board to floor visits by the executive team and non-executive directors. Information from these visits was linked into the quality governance committee meeting for further assurance, follow up and contemporaneous understanding of their issues and progress. However, there was a concern from some of the non-executive directors that staff were not always made aware of feedback resulting from these visits.

The trust also had a schedule of patient safety visits. These occurred more than once a month and were attended by a member of the executive team along with a trust governor and non-executive director. We saw evidence that these were carried out consistently throughout 2017.
Staff were particularly complimentary on the visibility of the director of nursing and the chief executive. Although other board members and divisional leaders were not as visible across some sites as they would like.

Leaders at different levels told us that trust language had been too organisationally focussed rather than system focussed; feeling too entrenched in foundation trust competitiveness rather than partnership. This had hampered the ability to work at pace regarding quality improvement. However, we did see how significant development had commenced. Leaders across the organisation were taking steps to ensure a focus on balancing operational productivity within financial constraints post the decision not to progress with the transforming care together programme.

We also found that health visiting team leaders were unsure whether their team was meeting their KPIs for each contact. They told us that they did not receive reports on performance for each key contact so there is no local oversight of performance. This again was not known or actioned by senior leaders at trust board level. Therefore, they received no assurance that key performance indicators were met for the health visiting service. The health visiting service also did not measure any outcomes, the board had identified this concern just before our inspection visit and therefore the board could not be assured patients were receiving high quality care and achieving positive outcomes.

A key phrase referred to on a number of occasions from both executives and non-executives was that you “don’t know what you don’t know.” This was a concern, as the trust board should have measures and systems in place to robustly identify and address emerging concerns and safety issues.

**Board Members**
The chief executive had recently been appointed, March 2018. Other members of the team had joined in 2017. The director of nursing and therapies was about to leave and this post had been advertised at the time of our inspection.

<table>
<thead>
<tr>
<th>Role</th>
<th>Specific responsibilities/lead areas</th>
<th>Start date in role</th>
<th>Exec/Non- Exec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Chair of the Board of Directors and Council of Governors</td>
<td>November 2011</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td></td>
<td>Chair Nominations and Remuneration Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>Vice Chair, Chair Finance and Performance Assurance Committee</td>
<td>July 2012</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>Chair Audit Committee</td>
<td>October 2015</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td></td>
<td>Chair Charitable Funds Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>Chair Investment Committee</td>
<td>September 2015</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>Senior Independent Director</td>
<td>July 2015</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td></td>
<td>Chair Quality Governance Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td></td>
<td>June 2018</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td></td>
<td>March 2018</td>
<td>Executive</td>
</tr>
</tbody>
</table>
Within the routine provider information request the trust reported that 28% of the board members were British Minority Ethnic (BME) and 21% were female. There were no female Non-Executive Directors (NEDs) in post. NEDs told us that they had recognised a need to increase their diversity and their clinical knowledge and were in the process of appointing a fifth female NED with a clinical background. The board was also in the process of starting conversations about associate NEDs for succession planning and were currently identifying the skill set needed. These included those with a primary medical services or adult social care background to reflect the changing makeup of modern hospital trusts.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>25%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>All board members</td>
<td>28%</td>
<td>21%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P64 Board Members)
Vision and strategy

The trust strategy, vision and values did not reflect the current vision and values of trust staff. Work was well progressed to refresh the vision, values and strategy through the Fit for 2022 programme. However, the lack of an active and up to date strategy resulted in staff not always understanding how their role contributed to achieving the strategy and direction for the trust. The trust planned to launch the refreshed strategy in October 2018.

The trust’s vision and mission was focused on delivering the best possible outcomes for the communities that they served. The trust told us that they aspired to make a real difference through the core services that they delivered and the way in which they worked, in partnership with other organisations to deliver “Better Care and Healthier Communities”.

The trust told us the role that they played in achieving this was articulated through their mission: “to be a trusted expert provider of community services, an innovative partner working to support integration and deliver care that keeps people living independently for longer”.

Underpinning this were six values which were developed through engagement with staff and stakeholders. These were:

- **Value: Accessible Description**: We will provide a range of services that reach out into the community and meet individual need where everyone counts; celebrating diversity and valuing difference.

- **Value: Responsive Description**: We will listen and work with our service users and partners to meet needs and improve health and wellbeing. We will encourage innovation and excellence, celebrating success and learn from experiences.

- **Value: Quality Description**: We will provide safe effective personalised care to the highest standard, providing information to support service users and their carers to make informed choices.

- **Value: Caring Description**: We will deliver our services with respect, compassion and understanding where people are valued and we will act in their best interest.

- **Value: Ethical Description**: Promoting a culture of dignity and respect we will make morally sound, fair and honest decisions and be openly accountable. We will commit to investing wisely whilst being socially and environmentally responsible.

- **Value: Commitment Description**: Through our actions and commitment, we will strive to make a positive difference to people’s lives. We will value our staff, the commitment and contributions they make.

The executive team were aware of the trust vision and were working towards updating this.

The vision and values statements were incorporated into aspects of the trust's business and reporting arrangements and provided the basis for the trust's strategic objectives and quality priorities. They were also incorporated into the branding model for the trust.

Many engagement events were held to develop the trust's ambition, vision and value statements. Staff workshops were also underway to inform development of the trust's vision and values. This included external partners. The trust told us that the vision and values were continuously reinforced via a range of activities undertaken by organisational development and communications teams, including specific team development programmes, visibility for the values and the regular, well-established ‘Values in Practice’ (VIP) Awards (a staff recognition initiative using the values as awards categories).
The values were also shown on screen savers, staff bulletins and presented on board rooms. The board undertook an annual planning away day engaging with staff at band 8a above to consolidate annual objectives, quality priorities and risk and performance issues. This helped inform strategy planning.

The trust told us that their strategy was developed to accommodate commissioner and key stakeholder intentions and strategic development and investment plans. These were reviewed by the Quality Governance and Risk Committee from a quality perspective and to seek assurance on the sustainability of quality of the plans.

The trust also told us that their Board Assurance Framework (BAF) enabled effective monitoring of risks in relation to delivery of the Strategy. We saw that the items on the BAF loosely aligned to key areas of the strategy. An example of this was around workforce planning and staff retention.

The trust’s strategy was published in 2016 to include 2016 - 2021 and detailed six strategic intentions. Their six strategic objectives were known as the ‘6Ps’ and were the basis of their annual plan:

- **Strategic Objective 1. People**: To have a skilled, innovative workforce who are compassionate and caring, where staff are empowered to take action, and where customer service and clinical leadership are at the heart of our services.

- **Strategic Objective 2. Purpose**: To transform and deliver high quality, efficient, integrated services that enable the best possible outcomes.

- **Strategic Objective 3. Partnerships**: Develop effective partnership working with our stakeholders to provide integrated care and break down the barriers internally and externally to maximise the benefits of expertise in the organisation.

- **Strategic Objective 4. Promotion**: Promote community services and the trust, listen to and communicate clearly and effectively with all our stakeholders and members.

- **Strategic Objective 5. Price**: Secure our future through effective contractual terms supported by robust costing and information systems to meet all our statutory duties and financial targets.

- **Strategic Objective 6. Place**: Deliver services in the most appropriate location, supported by an efficient estate and effective informatics infrastructure.

The trust told us that the strategy was developed following a comprehensive review of the organisation’s strengths and weaknesses and in light of the local and national political and economic environments. There was an annual strategic objective away day in January 2018 included participation by governors and members. This day would also inform the strategy refresh.

Some board members told us that the strategy was very broad with little assurance surrounding the use of feedback to improve. They told us the current strategy was more of a statement and that previous visions and values were dated and not owned.

There were concerns from executives and leaders that the current strategy had been more financially led. Executives told us that they wished to see a change to a more clinically led strategy, detailing clear and quantifiable aims to improve and monitor services.

There was a clear financial theme to the BAF and strategy. This was not underpinned by robust quality and clinical strands to ensure that patient care was not compromised. An example of this was that in one area there were only 3.2 registered staff carrying a case load of 1,940 children against the Royal College of Paediatrics and Child Health 2015 guidance of 100 children or young
people per whole time equivalent practitioner. The position in the trust equates to approximately 600 children or young people per whole time equivalent practitioner. Many of these children and young people had a high level of risk management need and the levels of staffing risked those needs not being effectively addressed. The risks were present on the local risk register and listed as ‘likely’ and ‘major’. There were no business plans in place to address these identified risks or risk assurance documents relating to the trust board.

There was also desire from leaders to revisit recruitment objectives. The trust acknowledged they had high numbers of bank and agency staff and this highlighted a need to recruit. It was felt that the recruitment process had become too process led and untimely. As such, staff who wanted to remain with the trust were moving on due to lack of available positions.

Alongside the big conversation piece, staff workshops were being undertaken to inform development of the trust's vision and values post the non-acquisition of two mental health NHS trusts. Staff we spoke with said that as part of the big conversation they understood they could contribute to the strategy, which they stated they previously did not. However, there were some groups of staff who felt unable to have their voices heard. We heard from black and minority ethnic staff who were concerned the strategy would not encompass an approach securing equality and diversity issues across the trust.

However, whilst the inspection team found that work was underway to secure and launch a strategy setting the future, staff reflections also presented that at the point of the inspection, services, divisions and leaders felt the absence of drive and operational focus that a live strategy would offer. Leaders and staff reflected the cause of that to be that the last 18 months had been ‘frozen’ by the acquisition work.

The trust's ambition was to be a leading community organisation in Birmingham and Solihull. The board recognised that to achieve this they needed a highly engaged, agile and committed workforce, who able to deliver the right services at the right time. This would require high levels of engagement and empowerment, needing a strong shared purpose.

The CEO recognised that there was work to be done to refresh the vision, values and strategy and had launched the Fit for 2022 programme to deliver this, including a series of Big Conversations to engage staff. The Conversations had highlighted core values of respect, care, professionalism and openness. Systems such as Induction and VIP awards embedded existing values and more would be done to promote this during the autumn.

In the absence of electronic prescribing and medicines administration, the pharmacy department had been working to improve staff training, and patient experience. There was confidence the new strategy would be aligned to the sustainability and transformation plan and trust strategy and support developments.

The board planned to measure the success of the strategy via briefing sessions initially. Following which an annual pulse check will test staff commitment and enthusiasm.

**Culture**

Staff satisfaction was mixed. Staff did not feel actively engaged or empowered. Staff did not raise concerns each time they had them and felt were not always taken seriously, appropriately supported, or treated with respect when they did. People did not consistently receive a timely apology when something went wrong and were not consistently told about any actions taken to improve processes to prevent the same happening again. Staff development was not given sufficient priority in some areas. Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed.

The executive team felt there was a need to change the culture to ensure staff felt supported to report incidents and raise concerns. Leaders reflected that key message needed to include that reporting of incidents is a marker of positive practice, ensuring learning.
The executive team were aware of areas within the organisation deemed to present with a culture of divisional superiority and excellence. The culture may have affected responses to never events and learning. A review of the service had been commissioned to allow full understanding and as a means to identify any risks or issues.

Staff we spoke with shared their views that a lack of cultural awareness had resulted in miscommunication and disciplinary processes. The staff felt that in some investigations they had concerns regarding impartiality of the investigating manager. An example provided was that investigation managers may have already previously investigated individuals and did not offer impartiality.

At the time of our inspection the trust was actively rolling out ‘the big conversation’ which was a well-planned programme of staff engagement to offer consultation about, and seek the views of staff to inform the refresh to the vision, values and strategy of the trust. The big conversation events were due to complete by September ahead of an autumn strategy launch.

**Fit and Proper Persons Requirement: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5**

We reviewed the trusts’ Fit and Proper Persons Requirement (FPPR) policy and viewed four random sample directors’ personnel files on site; two executive and two non-executives. There was a designated person responsible for ensuring these files were updated and contained the necessary checks.

All four files contained an in date and signed copy of the trust’s declaration of compliance with the regulations. By signing the declaration, executives were aware they were confirming that they do not fall within the definition of an “unfit person” or any other criteria set out in the guidance, and that they are not aware of any pending proceedings or matters which may call such a declaration into question.

Of the four personnel files, we found only one file to be fully compliant with the regulation. We discussed our initial findings with the director of human resources who assured us that an audit had been undertaken immediately following the inspection. This supported the gaps we found.

However, on the well-led inspection we reviewed a further four personnel files; one executive and three non-executive and found that the files did not meet the annual checks required as set out in the regulation.

There was a lack of organisation to the files and on returning to review the files, despite a checklist having been added, this checklist was not fully utilised. Some files had an electronic signature on the declaration and no date of signature recorded which meant the trust could not assure us that the person had read and understood the policy.

We also found Companies House searches with incorrect details. This meant that the trust could not demonstrate compliance with the regulation or trust policy.

**NHS Staff Survey 2017 – results better than average of community trusts**

The trust had five key finding that exceeded the average compared to all community trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.95</td>
<td>3.80</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.12</td>
<td>4.08</td>
</tr>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>59%</td>
<td>57%</td>
</tr>
<tr>
<td>KF16. % working extra hours</td>
<td>69%</td>
<td>71%</td>
</tr>
<tr>
<td>KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>55%</td>
<td>53%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

**NHS Staff Survey 2017 – results worse than average of community trusts**

The trust had 22 key findings worse than the average compared to all community trust’s in the 2017 NHS Staff Survey:

- KF11. Percentage of staff appraised in last 12 months: 90% vs. 91%
- KF12. Quality of appraisals: 3.05 vs. 3.13
- KF20. Percentage of staff experiencing discrimination at work in the last 12 months: 13% vs. 9%
- KF21. % believing the organisation provides equal opportunities for career progression / promotion: 80% vs. 88%
- KF28. % witnessing potentially harmful errors, near misses or incidents in last month: 23% vs. 21%
- KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month: 89% vs. 93%
- KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents: 3.74 vs. 3.81
- KF31. Staff confidence and security in reporting unsafe clinical practice: 3.69 vs. 3.80
- KF17. % feeling unwell due to work related stress in last 12 months: 43% vs. 39%
- KF18. % attending work in last 3 months despite feeling unwell because they felt pressure: 56% vs. 55%
- KF19. Org and management interest in and action on health and wellbeing: 3.66 vs. 3.75
- KF4. Staff motivation at work: 3.88 vs. 3.94
- KF7. % able to contribute towards improvements at work: 70% vs. 71%
- KF9. Effective team working: 3.76 vs. 3.82
- KF14. Staff satisfaction with resourcing and support: 3.29 vs. 3.30
- KF5. Recognition and value of staff by managers and the organisation: 3.43 vs. 3.53
- KF6. % reporting good communication between senior management and staff: 33% vs. 36%
<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.79</td>
<td>3.86</td>
</tr>
<tr>
<td>KF22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>25%</td>
<td>23%</td>
</tr>
<tr>
<td>KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>24%</td>
<td>19%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

These survey findings reflect the issues that staff had concerns about when they spoke with us. However, the trust were sighted as to the level of concerns and had commissioned a review to focus on the scale of the issues and support with action planning. The review was underway at the time of inspection.

**Workforce race equality standard**

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

To preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.
The difference in the proportion of staff answering yes to the following areas was found to be statistically significant:

- KF21. Percentage of staff believing the trust provides equal opportunities for career progression and promotion
- Q17b – In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

Staff told us that black and minority ethnic (BM) colleagues had informed them that they did not report concerns at exit interviews because they feared they might not get references or be employed in the future.

Some staff are raising their concerns around the fairness of recruitment processes. They gave us examples of having experienced discrimination.

In the trust’s 2017 Workforce Race Equality Standard (WRES) Report, data showed that applications by BME staff were higher than those from white staff however the number of BME staff being appointed was lower; 13% of shortlisted BME staff were appointed compared to 18% of white applicants. The report highlighted that the reasoning behind this low appointment rate was low question scoring within the interview. The BME network had conducted their own analysis that supported this and highlighted that particularly at band 7+, vacancies showed equal white and BME applicants however appointments were made in favour of white candidates. During inspection, staff told us of the view that white counterparts were measured on potential and given training, secondments and learning whilst black counterparts were measured in bands. If not in the right band they could not progress. Examples were also given of several BME staff being in an uplifted role for an interim period but being unsuccessful at interview to become permanent.

Staff told us that they felt there was no equality and diversity (ED) culture or promotion of ED issues and there was initial resistance to establishing an EDHR strategy by the trust, but that this relented after pressure from commissioners. Staff were concerned that diversity and race were being confused with little recognition of diversity. The trust had since established an EDHR group, WRES steering group and service equality group, but staff felt there was still little recognition by senior leaders of a need for the trust to engage with the community.

The BME network felt unsupported to present reports and findings. An example was where the BME network prepared a paper and were not allowed to present it, instead it was presented by a senior colleague who had not initiated nor been involved in the work.

Staff we spoke with said that the board did not get an accurate picture of BME issues by senior managers. They felt that only positive information is escalated to senior managers. For example, only positive indicators from staff survey were escalated to senior levels. The BME network conducted their own assessment of staff survey data which highlighted some discrepancies. However, the trust’s formal BME network felt unable to publish their findings from staff survey as this would contradict what the trust had put into public domain. We escalated this to the board and saw a report to board which reflected both positive and negative views of staff.

The trust had employed a number of cultural ambassadors. However, staff told us that they felt the ambassadors’ skills and knowledge were not being fully utilised during staff investigations. Although ambassadors had recommended questions for investigation panels to ask which were now included during investigations. Staff felt that ambassadors were seen as challenging and ‘trouble makers’. There was a culture of staff being reluctant to approach ambassadors in case they were ‘causing trouble’. It was also suggested that staff were reluctant to approach the BME network for fear of reprisals and being branded ‘trouble makers’.

A group of staff informed us of their historical concerns that key messages re EDHR had not been heard at senior/executive level.
The staff we spoke with said the new chief executive officer appeared receptive to promoting EDHR issues and staff expressed their confidence in him to promote EDHR. The chief executive officer had provided funding to promote the BME concerns in a newsletter and attended a staff lunch to celebrate Eid. Staff had attended a ‘big conversation’ and felt it was ‘brilliant’ to be able to express their frustrations.

The trust was also in the process of recruiting to a cultural inclusion and engagement post at a band 8D to lead on EDHR issues. Staff were also aware of the independent review commissioned to focus on EDHR across the trust. They felt reassured that the executive team were taking steps to listen and learn from staff to secure positive improvements for BME and EDHR concerns.

The trust had produced their Equality, Diversity and Human Rights Strategy 2016 – 2018. This supported and committed the trust to integrating equality and diversity across a number of key areas. They acknowledged that success would depend on the commitment of everyone, at every level being prepared to support its implementation.

The trust described the scope of the strategy as: This strategy sets out how BCHC will meet the equality duties, as set out in the Equality Act 2010, by putting patients at the heart of everything. This will be achieved via effective engagement and involvement of local people in decision making. It will also include working in partnership with local people, local authorities and other health care providers, to improve health outcomes for all, including those specifically in the nine protected groups, as identified under equality legislation.

The strategy relates to any individual employed in any capacity by the trust, including staff, students, volunteers and third-party contractors. The trust Board will discharge legal and regulatory obligations under the Equality Act 2010 and provide competent, high profile, leadership of the Equality, Diversity and Human Rights agenda.

The trust will ensure that all policies, functions and services will be subjected to appropriate equality analysis to ascertain any differential impacts on groups with specific protected characteristics and will ensure that mitigating actions are put in place where required. Policies and strategies within scope include:

- The Workforce Development Strategy
- The Organisational Development Strategy
- The Equalities Policy
- The Dignity at Work Policy and Guidelines
- The Patient Dignity, Privacy and Respect Policy
- The Recruitment and Selection Policy
- The Health and Safety Policy
- The Performance Development Review Policy”


The board recognised in early 2018 that there were issues relating to the experience of black and minority ethnic staff that needed to be addressed. As a result, the trust commissioned a review. This review had not yet reported at the time of the inspection.

Friends and Family Test (FFT)

Staff at the trust were asked if they would recommend the trust as a place to work and if they would recommend the trust as a place for care. The following chart shows how the trust performed in comparison to all other community trusts that took part.

Staff (%) that would recommend the trust for work, from January 2016 to September 2017.
Please note, data is not collected in quarter three of each year.

Overall, staff at this trust were less likely to recommend the trust as a place to work when compared to the average for all community trusts, although there is an upward trend over the entire reporting period. In quarter four of 2016-2017, the trust performed better than the average for all community trusts.

The response rate has declined from quarter one 2016-2017, decreasing 10 percentage points, from 16% to 6%.

Staff (%) that would recommend trust for care, from January 2016 to September 2017.
Please note, data is not collected in quarter three of each year.

As with the previous table, we can see that overall this trust performed worse than the average of all community trusts that took part in this test. Again, we can see a peak in quarter four of 2016-2017.

The response rate has declined from quarter one 2016-2017, decreasing 10 percentage points, from 16% to 6%.
(Source: Friends and Family Test Results)

Sickness absence rates

The trust’s sickness absence levels from January 2017 to December 2017 were worse than the England average throughout the entire reporting period. The trust’s trend over time reflected the national trend, with both sickness rates dipping in March and April 2017 before steadily increasing from May 2017 to December 2017.

Staff absence due to illness, from January 2017 to December 2017
Whistle-blowing

From January to December 2017, the trust reported 15 incidences of whistleblowing. The number of incidents above includes concerns and issues escalated via the Freedom to Speak up Guardian (FTSUG). The small number of incidents does not facilitate the identification of themes. The concerns raised above comprise incidents regarding consistency of network access to the electronic patient record system, allegations of bullying and harassment, other complaints against staff and allegations that appropriate recruitment processes were not followed.

Where appropriate, fact finds and investigations had taken place. Feedback has been provided to the whistle-blower where they were identified. Each investigation completed included the detail of further actions as appropriate. There was no material trending data to draw conclusions as the number of recorded whistleblowing incidents had remained in single figures over several years. Further work was being undertaken within the FTSUG and rising areas of concern to develop trending and reporting of concerns raised.

(Source: Routine Provider Information Request (RPIR) – P67 Whistleblowing concerns)

The trust had plans to enhance the FTSUG capacity via the introduction of a permanent role. At the time of inspection, the role was held by a senior leader with multiple additional portfolio pressures. It had been recognised that additional capacity was required. In the interim, the trust had also acted to secure ‘champions’ from across the trust and had taken steps to publicise the function, such as cascading promotion cards and leaflets.

Governance
The arrangements for governance and performance management were not fully clear or do not always operate effectively. Staff were not always clear about their roles, what they are accountable for, and to whom. However, there had been a recent review of the governance arrangements and work to refresh the flow and effectiveness of governance arrangements was ongoing.

The trust had structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. The trust had commissioned a review of its governance process in 2018 and was awaiting the outcomes.

The divisional structure was recently implemented and was in the process of becoming embedded. Divisional leaders felt empowered to make changes to their services and received support from senior leaders to improve the services they offered. However, there was little evidence of cross division working and learning and governance systems were not consistent across the divisions.

The first was open to members of the public. The second was a private session if required to consider issues which could not be dealt with in public due to staff, patient or commercial confidentiality. The trust board had a committee structure setting the flow for the key governance information to board. The board would receive a formal report or minutes from each of the tier three committees via tiers one and two. Board members felt this gave an opportunity for challenge and an escalation route. There were also divisional governance meetings where operational governance issues would be discussed and escalated through the formal committee structure.

Although the governance framework was well established, it was not always effective. Key issues of risk and patient safety were not always identified via these frameworks. The board was not sighted on key issues and the associated impact to patient care, such as high caseloads and missed antenatal visits.

Prior to our inspection we attended two board meetings. At both board meetings we could see the influence the non-executive directors had on the overall leadership of the trust. We saw an appropriate level of challenge from non-executive directors at board meetings. Non-executive directors told us they felt they had the right balance between support and challenge and had never had any resistance from the executive team in relation to challenge.

We were told that executive directors welcomed challenge. However, some executive directors told us they thought that more challenge would be helpful. Board meeting minutes we reviewed showed there were records of discussions and challenges about performance, accountability and confirmation of the actions agreed. However, the notes did not always capture the detail of full discussions.

Some non-executive directors told us that action plans were viewed by board and in isolation of oversight of progress operationally. It was felt that updates of operational progress would be beneficial. This had been raised as concern and the board were in the process of reviewing the efficiencies of the committee structure to ensure issues were raised in advance of the board meeting, enabling the board to take a proactive, rather than reactive approach.

A number of board members we spoke with said that board meetings lasted too long with a complex flow of messages from divisions to board. There was an awareness of some of the key risks but timeliness to address the issues was a concern acknowledged by the trust. Board members shared a view that it was time to stop ‘doing’ and ‘be brave’ for example by reducing the number of committees, introduce flash reports and not hold retrospective discussion. There was a shared view from executive leaders that the board was too reactive and should move to discussions about ‘what was coming over the horizon’.

We heard that reporting presented to the quality, governance and risk committee (QGRC) did not receive appropriate levels of challenge and the volume of information for review of the committee was unmanageable. The board assumed QGRC was operating effectively rather than seeking assurance that it was.
The chief executive and non-executive directors received appraisals and the trust chair assigned non-executive directors to specific committees (chair or member) according to their skills and requirements of the role. Specific champion roles were also assigned.

There was a mixed response regarding the committee structure, with some board members feeling assured that the structure worked and some feeling like they lacked that reassurance. There was also an executive view that some committees lacked clear aims. Most of the board members agreed there was room to streamline the structure. There was executive consensus that timeliness of reporting into the tier one committees could be improved with some information being received into the finance and performance assurance committee two days in advance of the board meeting, giving very little time to respond.

The chief pharmacist understood and could explain the existing medicines optimisation strategy and discussed how it was due to be updated as it did not include a link to the trust priorities, the sustainability and transformation plan or how the team would move forward with electronic records. There was no deputy in post and deputy functions were carried out by a locum pharmacist. Previously the role has been performed for three years under a verbal agreement without a job description. The structure of the department did not enable clear identification of where the pharmacy team would be hosted, or from when. However, we did not see that the risk relating to the low number of staff trained in medicines management across all divisions.

The trust had invested in a self-service reporting tool. One element of this tool enabled staff members to conduct self-assessment reviews. These reviews included assessments of the individuals and teams against the five CQC domains utilising CQC workbook prompts. All reviews incorporated an element of staff discussion. These reviews were underpinned and guided by information on areas of quality and safety identified through the trust’s essential care indicators.
Once completed the reviews were then aggregated to give a divisional rating of either outstanding, good, requires improvement or inadequate.

Financial governance is well established. The divisions are involved in the budget setting process with the aim of ensuring the outcome is owned by local teams. Divisions are responsible for the identification of and delivery of CRES. There is a regular process for holding divisions to account for their financial delivery through a variety of methods. These include the monthly budget reporting process, Performance and Programmes Management Board (PPMB), finance performance and improvement committee (FPIC) and the Board.

**Board Assurance Framework (BAF)**

The trust’s 2018/19 BAF had the following six objectives:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>To transform and deliver high-quality, efficient, integrated services that enable the best possible outcomes through our integrated delivery models</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>To have a skilled, adaptable, innovative and diverse workforce that is valued and supported and empowered where compassionate and caring leadership are at the heart of our services</td>
</tr>
<tr>
<td>Price</td>
<td>To secure our sustainability within the wider system through efficient use of resources and effective commercial relationship management.</td>
</tr>
<tr>
<td>Promotion</td>
<td>To promote the organisation and integrated care services that we and our partners deliver by engaging and effectively communicating with all of our stakeholders.</td>
</tr>
<tr>
<td>Place</td>
<td>To deliver services flexibly in the most appropriate patient centred location, supported by an effective and efficient fit for purpose shared estate.</td>
</tr>
<tr>
<td>Partnership</td>
<td>To develop effective partnerships, breaking down any barriers in order to provide integrated community care to maximise the benefits of expertise in the organisation to our partners and communities.</td>
</tr>
</tbody>
</table>

The objectives were then underpinned by the following quality priorities:

<table>
<thead>
<tr>
<th>Quality Priority 1:</th>
<th>Protecting staff from violence, harassment and bullying</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Priority 2:</td>
<td>Patient safety programme</td>
</tr>
<tr>
<td>Quality Priority 3:</td>
<td>Improve documentation</td>
</tr>
<tr>
<td>Quality Priority 4:</td>
<td>Patient outcomes</td>
</tr>
<tr>
<td>Quality Priority 5:</td>
<td>Enhancing patient experience</td>
</tr>
<tr>
<td>Quality Priority 6:</td>
<td>Information technology to improve patient care</td>
</tr>
<tr>
<td>Quality Priority 7:</td>
<td>Improving staff engagement</td>
</tr>
</tbody>
</table>

(Source: Trust data return: DR132 ENC 6 - Board Assurance Framework 2018 19)

The BAF was a mechanism by which the board considered the strategic objectives for the trust for the year. Aligned to each objective were a number of quality priorities. Some board members shared their views that the objectives and risks were too generic with vague statements. The consequence being that the board were not sighted of specific issues. It was also felt that greater pace was needed in processes of oversight and flow of information to inform the BAF.

However, many executive leaders did consider that the BAF stimulated productive discussion at board, though acknowledged that there was a need to reconsider its effectiveness against its purpose.

Board members we spoke with told us of quarterly consideration of the BAF and the strategic priorities and risks. However, we reviewed a number of meeting minutes and could not see any refresh or development across the BAF across the quarters, with each set of minutes presenting the same updates and detail.
Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts to drive improvements, however these were not functioning effectively. There was limited or ineffective investigation to inform learning and no robust process for following up on learning to ensure that any developments had been embedded.

Each division had its own risk register that informed the corporate risk register, known as the high-level risk register. The corporate risk register was presented to the trust board meeting every month. The divisions reported into to the risk management committee. The committee challenged risk ratings and the detail and subsequently reported onwards to QGRC.

Divisional directors were responsible for managing risk. However, we found that these accountabilities were ineffective, demonstrated by the length of time issues had remained on the risk register and lack of review and or reported plan to manage progress. An example was the length of time the issue had been known in relation to the delay to sending clinic letters within children’s services.

The pharmacy department did not have or maintain a risk register. However, they could feed into the corporate risk register. Risks were graded and looked at regularly at a governance meeting. However, recent risks had been removed for pharmacy as they were graded as “low” and work was underway to removing the risk. However, the risk remained and so should have remained on the register.

We reviewed the safeguarding policy and associated procedures. There was a lack of clear procedures or guidance. Whilst we made subsequent information requests to ascertain the detail, there was a risk. In some areas of the children and families division, staff neither knew what to look for and then what to do if they uncovered suspected abuse or neglect. We found no internal or external contact details, which created a risk for busy staff not having the time to ensure the several suggested searches to ascertain who to contact. This could dissuade staff from making a referral. During our inspection we had concerns about staff demonstrating professional curiosity in line with policies in place. We did not have assurance all staff had an understanding of actions to take when they may have concerns. An example of this was when we passed on a concern about staff understanding of the policy in one part of the service. In response to this, the action taken was not aligned to policy. We did not have assurance that staff in local teams or the senior management within the division or executive had an understanding of the response required when concerns were raised. There were also safeguarding concerns related to the non-compliance with Fit and Proper Person Requirement, with regard to the lack of up-to-date disclosure and barring service (DBS) checks, and the unclear transition planning for children moving into adult services.

There was a lack of evidence of learning from incidents. There was an example of two incidents which involved the same service user. The service user had been involved in a serious incident and on notification of this incident it was learned that the same service user had had a similar near miss prior to the second event. Documentation received showed that the trust had investigated both incidents as one incident. The investigation had identified that the trust had been slow to act on learning from the near miss.

Trust corporate risk register
The trust provided a document detailing their highest profile risks. Each of these had a current risk score of 15 or higher. Details of the 14 risks with a current score of 15 or more are shown below:

<table>
<thead>
<tr>
<th>Directorate admitted</th>
<th>Title</th>
<th>Rating (current)</th>
<th>Rating (Target)</th>
<th>Date added</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Community Services Division</td>
<td>Risk that IMT over activity is impacting on quality of care and wellbeing of staff</td>
<td>20</td>
<td>6</td>
<td>March 2017</td>
</tr>
<tr>
<td>Dental Services Division</td>
<td>Financial loss to BCHC of £2,113,803 due to loss of national funding resulting in School of Dental Hygiene &amp; Therapy closure</td>
<td>20</td>
<td>12</td>
<td>November 2016</td>
</tr>
<tr>
<td>Dental Services Division</td>
<td>Organisational Risk of Financial Loss due to changes in Trainee Dental Nurse Diploma funding</td>
<td>20</td>
<td>12</td>
<td>December 2016</td>
</tr>
<tr>
<td>Business and Organisational Development Directorate</td>
<td>External Cyber security threats create a risk of disruption to services and loss of data</td>
<td>16</td>
<td>4</td>
<td>August 2016</td>
</tr>
<tr>
<td>Children and Families Division</td>
<td>Post TUPE of ADHD Nurses, BCHC has continued to hold clinical risk and accountability for new ADHD referrals.</td>
<td>16</td>
<td>6</td>
<td>December 2015</td>
</tr>
<tr>
<td>Dental Services Division</td>
<td>There is a risk of income loss as a consequence of activity omissions within NHSE Contractual SLAM submissions</td>
<td>16</td>
<td>3</td>
<td>December 2017</td>
</tr>
<tr>
<td>Dental Services Division</td>
<td>Inability to provide sedation activity &amp; teaching due to lack of sedation qualified dental nurses</td>
<td>16</td>
<td>4</td>
<td>January 2018</td>
</tr>
<tr>
<td>Dental Services Division</td>
<td>Re-tender of Community Dental Service</td>
<td>16</td>
<td>8</td>
<td>February 2018</td>
</tr>
<tr>
<td>Urgent Care Service Division</td>
<td>AF18/21 - Risk to care delivery and BCHC reputation due to staffing issues within HMP by prison staff</td>
<td>16</td>
<td>6</td>
<td>March 2017</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Urgent Care Service Division</td>
<td>Financial Cost of new Enteral Feeding contract - June 2019</td>
<td>16</td>
<td>4</td>
<td>March 2018</td>
</tr>
<tr>
<td>Children and Families Division</td>
<td>ASD School Age Waiting list - risk to children on waiting list if not being seen or assessed</td>
<td>15</td>
<td>2</td>
<td>January 2017</td>
</tr>
<tr>
<td>Children and Families Division</td>
<td>There is a risk of negative impacts on children, families, staff and other services because of long waits in the CDCs</td>
<td>15</td>
<td>6</td>
<td>January 2017</td>
</tr>
<tr>
<td>Children and Families Division</td>
<td>There is a risk that children's needs are not met because of the constraints on access to children's Speech and Language Therapy</td>
<td>15</td>
<td>2</td>
<td>October 2017</td>
</tr>
<tr>
<td>Children and Families Division</td>
<td>There is a risk of a loss of £4.2 million impacting on the 5-19 school health service due to commissioner budgetary constraints.</td>
<td>15</td>
<td>8</td>
<td>December 2017</td>
</tr>
</tbody>
</table>

(Source: Trust data return DR74)

The corporate risk register identified the responsible director, the risk, the level of risk, gaps in assurance and controls in place to manage the risk. It was difficult to see an evaluation of the mitigating measures, when risks were updated, or if a review had occurred. One risk had originally been entered in 2011 and related to untimely and inappropriate management and diagnosis because of inability to access appropriate IT systems. This risk had been reduced from a rating of 15 to 6 and had a control in place which involved paper records being in place. The trust had identified a gap of paper results being lost prior to appointment. There was no further commentary as to whether the control taken had been successful or the gap had been mitigated or dates added to show a review had taken place.
An additional risk was that for children presenting with Autistic Spectrum Disorder (ASD) the length of the waiting list was resulting in untimely assessment. The risk stated there were currently 430 children on the waiting list who had been waiting between 1-2 years for a diagnosis. The control in place was that the ASD waiting list initiative was commissioned by the CCG to review the clinical model, MDT and reduce waiting list. This meant the trust was not meeting its 52-week referral to treatment times. There was a backlog of clinic letters from the community paediatrics clinics. Around 3,000 letters were overdue and an associated risk that children may not receive appropriate care if clinical letters are not sent out in a timely manner. This was added to the risk register in 2015, with a review date of July 2018. The trust had reviewed it at three monthly intervals. On discussion with the board, the backlog had actually been cleared with the introduction of a digital system. The risk register had not been updated to reflect this. Whilst we could see some reviews the mitigatory actions were not effective in addressing the risk.

The board could therefore not be assured as to the accuracy and timeliness of the risk register.

The high caseloads across the children and families’ division (CFD) were not visible on the corporate risk register. The executive team acknowledged they had not been sighted of the risk or the detail of the pressures to deliver the programme. There had been a concern that the division needed additional support since February 2018 but this had not been raised as a stand-alone risk. The board intended to conduct a quality review and learning exercise as a result of the inspection team highlighting the risks and the significance of the impact upon the safety of children, young people and families.

Most board members considered the risk register to be fit for purpose. Although there was also recognition that improvements were necessary. Board members acknowledged that there was an over reliance on divisions to assess and manage risk and ensure lessons from incidents. Some executives felt that this facilitated too much emphasis on detail, and the board “could not see the wood for the trees”.

When questioned, most of the board members could not name the top three corporate risks. This highlighted the lack of oversight of the risks.

There was a reliance on external organisations to highlight risks and areas for improvement. There was confidence that the review of the board effectiveness would show an opportunity to make improvements in the risk register and BAF, including adding transparency by strengthening the gaps in assurance and controls, actions and response. The board saw it as an opportunity to redefine their risk profile and oversight.

The board were confident that they had a clear overview of the divisions with a suite of essential care indicators and therefore they felt assurance was strong. There was also recognition that some divisions accepted reassurance rather than pursuing assurance.

The trust used an online incident reporting system to monitor all incidents and complaints. These were then fed into the risk management committee for consideration. The trust were concerned that staff were under reporting; staff had told us of instances where teams had been discouraged from reporting by managers. The staff survey results reported that the percentage of staff reporting errors, near misses or incidents witnessed in the last month was below the national average. It was felt that a piece of cultural work was required to address the under-reporting issues and encourage reporting and escalation. However, the board were unable to assure themselves as to whether incidents were being reported at the time of inspection and there was no evidence as to how assurances were being driven.

As a response to a falls incident, the trust had removed all sensor equipment (that is utilised within adult inpatient areas) until all relevant staff had been fully trained. On examination of the root
cause analysis, it was noted that the Trust had allocated a deadline which fell 5 months after the incident in which to ensure all relevant staff were trained in the use of the equipment. During this time period, the sensor equipment was not made available as a mechanism to mitigate the risk of patient falls. However all adult inpatient areas continued to undertake falls risk assessments on admission and on an ongoing basis as required, in order to ensure appropriate action plans were in place to mitigate the risk of falls. Furthermore, there were additional interventions in place to prevent falls such as one to one supervision, utilisation of high visibility locations, toileting regimes, clear information for patients and carers, training and staff safety huddles.

In April 2018, the trust had implemented a 24-hour rapid response process for managing serious incidents. This included a requirement for staff to identify immediate learning. The divisional lead nurse and director of operations were in the process of testing the process including testing the response to action plans coming out of the serious incidents.

### Information management

The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. Leaders and staff did not always receive information to enable them to challenge and improve performance. Information was used mainly for assurance and there was concern that it was reactive rather than proactive. However, there was a drive to improve information management with the implementation of the trust's key performance indicators.

Data quality strategies were managed through the information programme and underpinned via a trust wide policy approved by the trust information board. The board had an aim to create a culture of commitment to continual improvement of data quality. The commitment included governance, policy, process, training and monitoring and sets out five areas of activity:

1. Alignment to the trust’s information strategy which focused on how the trust was developing information services to ensure data was of good quality to provide a solid foundation for intelligent and insightful decision making
2. Create awareness to all staff of the importance of good data quality and their responsibilities
3. Ensuring governance and continual monitoring of data quality process were in place to drive data quality improvements
4. Ensure relevant NHS and national information quality standards were applied
5. Ensure systems and processes in place to secure data quality within day-to-day business activity reduce duplication and quality errors.

(Source: Routine Provider Information Request (RPIR) – P71 Data Quality)

The information management team and information technology (IT) team were aligned to separate divisions. The information team reported to the director of finance and the IT team reported to the chief operating officer. Within the information team there was a data quality sub team who checked data quality and managed the trust’s relationship management system. The information team had information quality specialists. The specialists aligned to at least one division, supporting business intelligence managers to develop and deliver a data quality service to all trust users. The data quality work stream within the information strategy addressed the requirement to continuously maintain data quality, completeness, timeliness and accuracy in line with business change.

The trust was a member of national benchmarking networks for evidence on shared practice for comparable statistical information. However, the trust acknowledged that there were challenges to the quality and accuracy of data and that had affected internal and external reporting.
The trust had a quality dashboard in place which contained several key performance indicators, known as essential care indicators (ECIs). These were reported in the monthly Quality and Performance Report (QPR). The ECIs gave an overview of data such as number of falls, staffing and infection prevention control. The ECIs were specific for each division, the only exception being the children and families’ division (CFD) which had yet to have ECIs implemented. This lack of ECIs had contributed to a lack of board oversight of issues within the CFD; namely the large caseloads and health visitors not achieving all five key points of contact within the healthy child programme. The CFD ECIs were due to be added to the QPR in July 2018. The board considered the QPR was the most useful document to drive the organisation moving forwards. We discussed the lack of ECIs across CFD with trust and were provided with a milestone and action plan to address this gap.

There was inconsistent board assurance regarding data quality. We were told of occasions where the board were informed they needed to read the narrative rather rely on the data.

However, data quality for estates and quality was well organised having a single point of access for all queries.

The trust had identified a risk that their internal systems did not communicate with one another. The trust had moved to an electronic patient record (RIO) and it had become apparent that it was not currently possible to produce the RIO in an acceptable format for sharing outside of the trust. This could result in the detail behind concerns relating to a child/family not being shared with a receiving authority when a child and, or family transfer out of area, which in turn could result in a safeguarding incident. The trust was managing this by utilising paper copies for patient transfer summaries and working on creating a bespoke front-end report for the children and families’ division.

The big conversation included a collation of views about systems integration. Staff felt there was an appetite from the trust to improve integration. The trust had a data warehouse with an aspiration that all systems would inform one platform. At the time of the inspection, all clinical systems informed the warehouse; however a limited number of the corporate systems such as ESR and the financial ledger were connected. This had led to difficulties in linking data into one concise report.

There was an agreement in place for the trust to access partner organisation systems such as a local acute trust to access clinical results. The trust was in discussions with other organisations to secure similar agreements. However, no timeline was available other than an expectation it would occur within three months. This access was provided through the intranet and staff were issued with login credentials.

Across Birmingham there was a central care record being developed in two phases; phase one was integration of GP practices on to the system and was completed, phase two involved adding the provider systems to the record to provide their data. Once phase two was complete the trust would have visibility of all care records in Birmingham.

There was no formal route of obtaining feedback on the pharmacy service delivery or pharmacy performance both individually or as a department.

The trust had been affected by the international cyber-attack in 2017. The trust had since implemented an upgrade to their systems to protect from future attacks and had instigated a ‘rebuild’ program. Staff attended hubs to have their computer and mobile device equipment checked for the virus and replaced where needed. Lessons learned from the attack included to simplify staff communications and work with a mobile device supplier to introduce a mass text feature. The trust also worked with NHS Improvement and an external agency who undertook detailed cyber audits. Both generated action plans which were being reported and updated to the Audit Committee. In May 2018 the IT team did a daily “stand-up for intelligence” gathering exercise to highlight the ongoing risk to staff. This was also reflected on the trust’s corporate risk register at a risk rating of 16; the highest risk was rated 20.
High level financial summary information is available at Board level, with a clear statement of the financial position of the trust. Finance is included as a section within the Quality and Performance Report. The finance report, submitted to finance, performance and assurance committee (FPAC) includes a greater granularity of detail including divisional analysis of the income and expenditure, cash flow, capital spend, agency and temporary staffing.

**Engagement**

The divisional structures in governance arrangements did not ensure efficient flow of information. There had been insufficient attention to appropriately engage with those with protected equality characteristics. Feedback was not always reported or acted on in a timely way. However, the trust was in the process of improving staff engagement with a number of big conversations, designed to help refresh the trusts strategy, visions and values. This approach would enable a range of people’s views and concerns to be heard and acted on to shape services and culture.

We heard from staff, including board members that middle managers were reluctant to pass on difficult messages. The efficiency of staff engagement and openness to change had been hindered as a result.

Communication systems such as the intranet were in place to ensure staff had access to information about the work of the trust and the services they used. However, staff told us and we saw evidence of policies being placed on the intranet in draft form for example a cleaning policy dated 2015.

The trust had upskilled existing staff to undertake the role of cultural ambassadors but staff felt the ambassadors’ skills and knowledge were not being fully utilised during staff investigations. There was a culture of staff being reluctant to approach ambassadors or the BME network for fear of reprisals and being branded ‘trouble makers’.

The trust was actively involved and engaged in collaborative work with external partners and recently become actively re-engaged with the local STP.

As part of the strategy, visions and values refresh, the CEO had invited 470 staff from all divisions and staff groups to ‘the Big Conversation’. Some staff attended a one to one meeting with the CEO to talk through what their key issues/areas of concern were and to shape the new approach. Feedback to this approach has been positive and as a result an additional event was held. The initial key themes included:

- Improvement to information technology was needed
- There was an increase in demand on the workforce
- The trust needed to engage more; not always equity, not always heard, changes are imposed
- A refresh of the intranet
- Increased usage of social media
- Listen to staff and don’t bombard with reminders
- Encourage staff to a positive place
As the outcome of the Big Conversation, the refreshed strategy, vision and value were due to be presented to the board in October 2018. In the interim the trust had introduced a local “pulse” survey to supplement the data gathered from the national staff survey and was in the process of collating the results.

The trust employed an associate director in the role of freedom to speak up guardian (FTSUG) role who had no protected time to carry out the role. There was recognition from the board that the role needed to be full time. The trust was recruiting a new FTSUG whilst also introducing champions from within the divisions to support the role. In a recent board discussion, the board also recognised a need to improve the understanding of the role to make sure it was embedded in current processes. The board encouraged staff to go direct to them or the Chief Executive Officer (CEO), an example was given of clinicians raising concerns regarding cleanliness and the CEO acting on them.

The board assured itself of the effectiveness and accessibility of FTSUG through both the quality governance and risk committee (QGRC) and the Public Trust Board. However, they acknowledged that there had been struggles with the confidentiality aspect of that role and a lack of formal reporting process on staff perception.

The board invited patients, their carers and service staff to board seminars where they could recount their ‘story’ and experiences of the services. Members of the board actively participated in a regular programme of patient safety visits with Governors to speak with staff and patients and triangulate this feedback with reports received at formal meetings. A review of the patient safety visit programme was undertaken in 2017 with changes to process and enhancements to the governance processes supporting the visits were made.

**Learning, continuous improvement and innovation**

There was a drive to secure continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. There was knowledge of improvement methods and the skills to use them at all levels of the organisation.

There were organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems, and ways of sharing improvement work. However, improvements were not always identified or action was not always taken. The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they started to be addressed.

The service made effective use of internal and external reviews. Staff were encouraged to use information and regularly take time out to review individual and team objectives, processes and performance.

There was trust board oversight and challenge of deaths to ensure that the reviews and investigations reduced or prevented reoccurring problems. Minutes of a recent trust board paper reviewed serious incidents resulting in death and any learning. The trust board received updates on actions taken to reduce the risk of similar incidents from reoccurring.

We assessed how the trust learnt from reviews and investigation of deaths. The approach tests the progress NHS trusts have made in meeting national guidance issued on March 2017 on learning from deaths, that sets out what families and carers should expect, and will highlight any good practices.

The trust had a policy in place to support the identification, reporting, investigating and learning from deaths. This reflected current good practice recommendations made in the recent National Quality Board’s publication, ‘National Guidance on learning from Deaths’. This guidance promotes the importance for trusts of identifying opportunities for improvements and engagement with
families and carers about the experiences of the people they cared for. There was an executive lead to promote learning from deaths who chaired regular reviews to identify if any deaths were preventable and if any patients were at increased risk of death while under the trust’s care due to their specific conditions. The trust held learning events for staff when it was identified patients were at increased risk of harm or death. This gave staff the opportunity to make suggestions for improvements. There was a learning from deaths action plan in place which the trust was following and regularly updated to monitor their progress against best practice guidance and improvement targets.

Systems for reporting and reviewing deaths were linked to the trust’s monitoring of compliance with their duty of candour. This identified if families and carers had received a full, fair and timely response to a person's death and details of circumstances that meant the person may not have received optimal care. The trust had notified other agencies such as the local authority and coroner of which deaths had been regarded as having a significant consequence to families, staff and organisations. However, we noted that on one occasion the trust had failed in their legal responsibility to notify the care quality commission of a death regarded as significant.

We found evidence of learning from deaths. In one instance, an investigation into an unexpected death highlighted concerns with staff management, internal communication and case allocations exposed the person to the risk of harm. The trust had conducted several reviews to identify learning from this incident which included the provision of additional staff training, reviewing investigative processes and safe staffing levels. This reduced the risk of other people being exposed to similar harm.

The trust had acted to understand the experiences of families, carers and staff who had supported people who died while using the service. This had led to the updating of bereavement information shared with families and carers and improving how they could feedback their experiences of their bereavement support.

Due to an increase in falls in adult inpatient areas, the trust had implemented a Falls Steering Group, chaired by the Director of Nursing and Therapies, they met to shape and implement an overall Falls Prevention work programme. This included:

- A multidisciplinary team (MDT) falls task group to support ward areas with the management of falls. The team proactively worked on the wards to roll out falls risk assessment documentation.
- The creation of a specialist enhanced dementia and falls cohort nursing team of trained Health Care Assistants, led by the dementia lead nurse. This team would be deployed to wards where patients required one to one supervision to reduce dependence on booking bank and agency staff and to ensure consistency in the trust approach to patients requiring high levels of supervision. A job description had been developed and recruitment has started to the posts with a view to initially implementing the model at Moseley Hall.
- A follow up to the successful Falls Summit, initially held in September 2017, to be arranged for summer 2018. The focus would be on evaluation of the environmental audits, a review of the new multidisciplinary team documentation and associated training.
- When Urgent Care and Rehabilitation services were merged to become the Adult Specialist Rehabilitation Division, best practice relating to falls risk assessments and care planning documentation had been rolled out across all other inpatient areas.

This work was currently in the early stages of being implemented and therefore it was too early to assess its impact.

We saw examples in services for children and families and community adult inpatients of systems being ineffective, and the organisation failing to learn. An example of this was children’s services failing to learn and take appropriate steps following a serious incident. Medical staff explained that the reporting system felt to be more complicated than necessary and so medical staff were less likely to report incidents. This resulted in a higher proportion of incident reporting via nursing staff.
Examples of innovative practice

A mobile application was developed jointly by the BCHC and the Lullaby Trust that allowed parents of new-born babies to go through a series of visual tests to assess the severity of their child's condition and respond accordingly.

Within the children and families division, a member of the paediatric physiotherapy team had undertaken a National Institute for Health Research (NIHR) portfolio study titled "Perspectives of walking aid users, their carers and therapists on designing walkers that encourage children with neuro disabilities to be more physically active (PLAY)". Neurological disabilities are caused by damage to the nervous system (including the brain and spinal cord) that results in the loss of some bodily or mental functions. The study involved holding focus groups with walking aid users, their parents and therapists to ask their opinions on adding technology to children's walking aids to provide feedback on their use and adding incentives such as games and reward systems to encourage increased physical activity in this sedentary group. The study had generated interest from equipment manufacturers who wished to incorporate the findings in their equipment development, and would be published shortly. The study was funded by an internal trust pump prime and external Physiotherapy Research Foundation grant (Part of the Chartered Society of Physiotherapy).

A workshop carried out at a special school with Small to medium enterprise (MIRA) to assess acceptability of their "exergames" system, which uses a popular gaming console to allow children with disabilities to use games as part of their ongoing rehabilitation. The trust had made a subsequent grant application to the NIHR i4i connect program and was awaiting its outcome.

Complaints process overview

The complaints team reported to the director of corporate governance. Historically the trust had experienced challenges responding quicker than six months. The team had been challenged to improve the pace of the response and that programme of work had reduced this to 17 weeks. With an overall aim of reducing response times of all complaints and introducing a framework for responding to complaints depending upon complexity. However, there was no timeline for this to be achieved within.

On the inspection, we raised a challenge regarding a lack of duty candour being triggered within the complaints process. The professional duty of candour: every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient’s advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient’s advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient’s advocate, carer or family) the short and long-term effects of what has happened.

In response the trust made alterations to the incident system, on which complaints were recorded, which enabled a process of triaging complaints and cross referencing them to see if an incident had been raised. This then triggered the duty of candour.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.
Question | In days | Current performance
--- | --- | ---
What is your internal target for responding to* complaints?
*Responding defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt | 3 working days | 100%
What is your target for completing* a complaint?
*Completing defined as closing the complaint, having been resolved or decided no further action can be taken | 180 days | 100%
If you have a slightly longer target for complex complaints, please indicate what that is. | N/A | 1,903 complaints resolved without formal process.

Number of complaints resolved without formal process* in last 12 months? (Date range January 2017 to December 2017) | Not provided |

From January 2017 to December 2017, the trust referred four complaints to the ombudsman (PHSO). Of these four:

- the trust was currently working on the action plan recommended within one complaint
- The decision on two complaints was awaited
- One complaint was not upheld.

*(Source: Routine Provider Information Request (RPIR) – P61 Complaints)*

**Number of complaints made to the trust**

The trust received 152 complaints from January 2017 to December 2017. A breakdown of complaints by core service is shown below:

**Trust level**

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>% of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services for Adults</td>
<td>70</td>
<td>46.1%</td>
</tr>
<tr>
<td>Dental</td>
<td>45</td>
<td>29.6%</td>
</tr>
<tr>
<td>Community Health Services for Children</td>
<td>30</td>
<td>19.7%</td>
</tr>
<tr>
<td>Community End of Life care</td>
<td>3</td>
<td>2.0%</td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Community Health Services for Adults</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

A breakdown by site can be seen in the tables below:

Anne Marie Howes Centre
### Birmingham Dental Hospital and School of Dentistry

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>% of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services for Adults</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Dental</td>
<td>41</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Community Unit 27

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>% of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services for Adults</td>
<td>2</td>
<td>66.6%</td>
</tr>
<tr>
<td>Community End of Life Care</td>
<td>1</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

### Moseley Hall Hospital

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>% of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services for Adults</td>
<td>10</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Priestley Wharf

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>% of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services for Adults</td>
<td>52</td>
<td>57.1%</td>
</tr>
<tr>
<td>Community Health Services for Children</td>
<td>30</td>
<td>33.0%</td>
</tr>
<tr>
<td>Dental</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>Community End of Life care</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

### West Heath Hospital

<table>
<thead>
<tr>
<th>Core Service</th>
<th>5</th>
<th>% of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services for Adults</td>
<td>10</td>
<td>100%</td>
</tr>
</tbody>
</table>

At trust level, most of complaints were about community adult’s services with 70 complaints (46.1% of complaints), dental with 45 complaints (29.6%) and community children’s services with 30 complaints (19.7%).

Regarding themes, the most prevalent them amongst complaints was provision of communication/information to patients (41.3%), all aspects of clinical treatment (34.9%), attitudes of staff (6.4%), personal records (6.4%) and admissions (3.7%).

(Source: Routine Provider Information Request (RPIR) – P61 Complaints)

### Compliments
From January 2017 to December 2017, the trust received a total of 325 compliments. We are unable to breakdown the data down into core service or theme, however the trust have provided us with a list of themes they have derived from their own analysis. These are:

- Praise for levels of care
- The caring attitude of staff – helpful, professional, kindness, compassion, patience
- Staff going the extra mile
- Delivering a great service
- Quality of service
- Fantastic team
- Knowledgeable, experienced, professional staff
- Patients feeling listened to.

(Source: Routine Provider Information Request (RPIR) – P62 Compliments)

Accreditations

NHS trusts participated in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Community health services

Community health services for children, young people and families

Facts and data about this service

We inspected community health services for children, young people and families as part of the new phase of our inspection methodology. The service was given a short notice period of two days to allow the inspection team to plan logistics and obtain consent to accompany staff on visit to patients in their own homes. We inspected the service from 15 to 16 May 2018 and followed up with an unannounced inspection on 23 May 2018.

The trust had a wide range of accessible and responsive universal and specialist services which were provided for children, young people and families in homes, schools and clinics across Birmingham, working closely with maternity, education, social care and third sector partners. It aimed to support every child from pre-birth to five years old with health visiting teams, which were part of the new Early Years Health and Wellbeing service, together with Children's Centres, from January 2018. Nurses in mainstream and specialist schools provided continuing health checks, immunisations and support. For children with additional needs, specialist support was also provided in families' homes, the five child development centres and special schools by teams of specialist nurses, community paediatricians and allied health professionals. Regional Child Health Information and Paediatric Sexual Assault Services were also provided by the trust.

Rehabilitation Services: Nutritional & Dietetics provided paediatric primary care services across the city.

Respite services were provided jointly with the local authority at Edgewood Road in a six-bedded bungalow which provided short breaks for children with long term conditions, disabilities and/or complex health needs from the age of five to eighteen years old.

Details of the locations at the trust that offer community services for children are below.

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team/ward/satellite name</th>
<th>Details of services offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turtles at Edgewood Road</td>
<td>Respite care centre</td>
<td>Respite care for children</td>
</tr>
<tr>
<td>Priestley Wharf</td>
<td>• Alexander HVT</td>
<td>Community and specialist services</td>
</tr>
<tr>
<td></td>
<td>• Aspire HVT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Aston HVT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CCN &amp; Palliative Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Central School Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Child Development Centres</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Children in Care Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Children’s Complex Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CHIS - South Warwickshire</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CHIS - Staffordshire and Shropshire Health Informatics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>Location site name</td>
<td>Team/ward/satellite name</td>
<td>Details of services offered</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>• CHIS West Midlands</td>
<td>• Elmdon HVT</td>
<td>• Immunisation</td>
</tr>
<tr>
<td>• Finch Road HVT</td>
<td>• Greet HVT</td>
<td>• Kings Heath HVT</td>
</tr>
<tr>
<td>• Hall Green HVT</td>
<td>• Harborne HVT</td>
<td>• Kings Norton HVT</td>
</tr>
<tr>
<td>• Ladywood HVT</td>
<td>• Medical Needs in Early Years</td>
<td>• North School Nursing</td>
</tr>
<tr>
<td>• Orchard HVT</td>
<td>• Occupational Therapy</td>
<td>• Orchard HVT</td>
</tr>
<tr>
<td>• Paediatric Eye Service</td>
<td>• Paediatric Sexual Assault Service</td>
<td>• Quinton HVT</td>
</tr>
<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Physiotherapy</td>
<td>• Saltley HVT</td>
</tr>
<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Speech &amp; Language Therapy</td>
<td>• Sandwell School Nurses</td>
</tr>
<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Speec &amp; Language Therapy</td>
<td>• Selby Oak HVT</td>
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<td>• Paediatric Sexual Assault Service</td>
<td>• Staffs HVT</td>
<td>• Soho HVT</td>
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<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Staffordshire Mainstream School Nursing</td>
<td>• South Central School</td>
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<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Staffordshire Special School Nursing</td>
<td>• South West School</td>
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<td>• Paediatric Sexual Assault Service</td>
<td>• Sparkbrook HVT</td>
<td>• Sparkhill School Nurses</td>
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<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Speech &amp; Language Therapy</td>
<td>• Special School Nursing</td>
</tr>
<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Speech &amp; Language Therapy</td>
<td>• Sutton HVT</td>
</tr>
<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Staffs HVT</td>
<td>• Sutton HVT</td>
</tr>
<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Staffs HVT</td>
<td>• Young Peoples' Sexual Health Service (Special Needs)</td>
</tr>
<tr>
<td>• Paediatric Sexual Assault Service</td>
<td>• Staffs HVT</td>
<td>• Community Paediatrics</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Universal services for children and families

Universal interventions support the whole population, i.e. whole class or whole setting/school and ensure all children have appropriate language and communication opportunities. This level includes workforce development, access to appropriate information, creating communication friendly environments and whole class/setting/school intervention approaches.

During the inspection, we visited the following health visiting teams and services:

- Saltley Health Visiting Team;
- Sutton Coldfield Health Visiting Team;
- Finch Road Health Visiting Team;
• Dove Health Visiting Team;
• Poplar Road Health Visiting Team; and
• Millennium Health Visiting Team
• Child Health Information Service (CHIS)

During the inspection visit, the health visiting inspection team:
• Spoke with two children’s relatives;
• Observed staff giving care to 18 children, which included care given in four patient homes;
• Reviewed two patient records;
• Reviewed trust policies;
• Reviewed performance information and data from, and about the trust;
• Obtained patient feedback from experts by experience.
• Spoke with 21 members of staff at different grades from band three to band eight including health visitors, assistant practitioners and administration staff;
• Spoke with two operational managers, five team managers and one clinical practice teacher.
• Spoke with two CHIS managers

Specialist services for children
Specialist interventions are in addition to the universal and targeted offer for those children and young people who require a highly individualised and personalised programme of work. This group includes children with complex learning and communication needs and those children who are cognitively able and have specific speech, language, mobility or communication needs.

During the inspection, we visited the following school nurses/ specialist service teams and services:
• Victoria Special School nursing service
• Turtles at Edgewood Road
• Central Booking services (children)
• The Children in Care team
• Two Child Development Centres

During the inspection visit, the school nurses/specialist service inspection teams:
• Spoke with four children/young people
• Spoke with five relatives of children using the services
• Observed care to three children/young people
• Reviewed 11 patient records
• Spoke with 37 members of staff at different grades from band 3 to band 8 nurses, safeguarding children leads; doctors, consultants and therapists; divisional leaders and clinical director for children and families.
• Reviewed trust policy documents and strategy plans.

The Care Quality Commission last inspected the service in June 2014 as part of its Comprehensive Inspection programme and rated the community health services for children and families as ‘Good’ overall with the responsive domain rated as ‘Requires Improvement’. The
community health service for children and families was issued with seven recommendations that they should implement for service improvement in the safe, effective and responsive domains.

During this 2018 inspection, we looked at changes the community health services for children and families had made to address these concerns.

<table>
<thead>
<tr>
<th>Is the service safe?</th>
</tr>
</thead>
</table>

Our comprehensive inspection of 2014 rated safety as ‘Good’. However, this 2018 inspection found significant shortfalls and some concerns over safety and we have now rated the service as Inadequate.

**Mandatory training**

**The service provided mandatory training in key skills to all staff.** It did not make sure all staff groups completed it.

**Mandatory Training completion**

At our last inspection of 2014 we said the trust should ensure staff attendance at mandatory training improved. This inspection showed improvement was still needed particularly for medical and dental staff.

The service provided training and regular updates in the systems and processes. There was a programme of mandatory training and updates for staff, which included, but was not limited to fire safety, resuscitation, infection prevention and control, information governance and moving and handling. The full list, along with the percentage of staff that had completed the training, can be seen in the table below.

The trust set a target of 85% for completion of most mandatory training courses, except for information governance, child protection level 1 and safeguarding adults level 1 which all had a completion target of 95%. A breakdown of compliance for mandatory courses from April 2017 to March 2018 for medical/dental and nursing staff within community services for children is below.

### Medical and dental staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff last year</th>
<th>% Completion</th>
<th>Trust Target (%)</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying &amp; Harassment</td>
<td>39</td>
<td>39</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>32</td>
<td>39</td>
<td>82.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>31</td>
<td>39</td>
<td>79.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT/Wrap</td>
<td>31</td>
<td>39</td>
<td>79.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus</td>
<td>31</td>
<td>39</td>
<td>79.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>26</td>
<td>39</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>26</td>
<td>39</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>25</td>
<td>39</td>
<td>64.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>24</td>
<td>39</td>
<td>61.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>22</td>
<td>39</td>
<td>56.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical and dental staff within the children and young people service met the completion target for one of the 10 training courses made available to staff.

### Nursing and midwifery staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff last year</th>
<th>% Completion</th>
<th>Trust Target (%)</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying &amp; Harassment</td>
<td>542</td>
<td>542</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT/Wrap</td>
<td>538</td>
<td>542</td>
<td>99.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>512</td>
<td>542</td>
<td>94.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>472</td>
<td>524</td>
<td>90.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>481</td>
<td>542</td>
<td>88.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>480</td>
<td>542</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>477</td>
<td>542</td>
<td>88.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus</td>
<td>473</td>
<td>538</td>
<td>87.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>476</td>
<td>542</td>
<td>87.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire</td>
<td>473</td>
<td>542</td>
<td>87.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff within the children and families service met the completion target for nine of the 10 training courses made available to them.

(Source: Routine Provider Information Request (RPIR) – Training tab and Trust data return DR2, DR4 and DR11)

### Universal services for children

There were effective processes for ensuring staff completed their mandatory training. Within the health visiting service, team leaders were responsible for ensuring their team were compliant with mandatory training. Each month, team leaders accessed an electronic report highlighting the mandatory training compliance rates within their team. The report identified which staff had completed training courses, when training was due and when it was overdue. If a health visitor, assistant practitioner or administrator was due to complete training, their team leader sent out email reminders to book onto the relevant training course. The team leader continued to chase them until training had been completed. Staff confirmed they received email reminders when they were due to complete training. Staff also had access to their own individual training records and could review what training they had completed and what was due for renewal.

The quality of mandatory training was described as good by staff. Staff, including health visitors, assistant practitioners and administration staff, within the health visiting teams, told us the quality of training provided to them was high. We were told the training was engaging and was delivered either face to face and could be accessed online.

Several staff commented that training throughout the trust had become better organised over the previous 12 months.
Safeguarding

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

The trust had a dedicated safeguarding team which included the safeguarding lead nurse; who was the deputy director of nursing and therapies. The safeguarding team supported staff within the trust, provided education and training and acted as an internal point of contact for staff. Staff we spoke with in the division confirmed this. The team also worked with other local stakeholders and agencies to run campaigns for proactive child protection. They told us these have recently included the ‘Who’s in charge?’ campaign to educate parents about the impact of alcohol and drugs consumption on the safety of a child depending on their care.

The trust did not have its own set of safeguarding children procedures. It was committed to the West Midlands Child Protection and Safeguarding Procedures and staff were expected to follow these procedures. We saw these procedures were accessible to staff on line and staff we spoke to were aware of them.

The trust had a safeguarding children policy and had reviewed it in February 2018. The trust also endorsed the Birmingham Safeguarding Board (BSB) protocols and contributed to the multi-agency safeguarding hub (MASH). Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff. Trust responsibilities and resources for safeguarding were identified throughout the governance structure of the division from the safeguarding named nurses up to the deputy director of nursing.

However, during our inspection we passed on a concern about staff understanding of the policy in one part of the service. In response to this the practice undertaken by divisional leaders was not in line with trust policy or BSB procedures and could have compromised the safety of the child.

We reviewed the trust’s safeguarding children policy and noted: it set out in general terms what safeguarding children is but it lacked detail of how the services worked with others such as the local authority and the police. It did not address domestic abuse and the particular issues that arise for children with complex health needs and their families were not specifically acknowledged. However the trust did have a dedicated Domestic Abuse Policy ratified by committee in April 2018 and due for issue 22 May 2018.

There were no procedures, no guidance and no contact details either internally or externally. This created a risk for busy staff not having the time to do the several suggested searches to find out who to speak with it did not effectively support an approach that collaborates with regional procedures.

Safeguarding Training completion

The trust set a target of 95% for completion of safeguarding children Level 1 and 85% for safeguarding children Level 3. The second target was lower than comparative national current trends for community children’s services where we have found the average is at least 90%. A breakdown of compliance for safeguarding courses from April 2017 to March 2018 for medical/dental and nursing staff within community services for children was below the trust target.

The trust did not offer level 2 safeguarding or child protection training to medical and dental staff. This approach did not meet the safeguarding children and young people: roles and competencies for healthcare staff Intercollegiate Document (2014) recommendation that ‘those requiring competences at Levels 1 to 5 should also possess the competency at each of the preceding levels’.
Medical and dental staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff last year</th>
<th>% Completion</th>
<th>Trust Target (%)</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection Level 1</td>
<td>32</td>
<td>39</td>
<td>82.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Child Protection Level 3</td>
<td>28</td>
<td>38</td>
<td>73.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>29</td>
<td>39</td>
<td>74.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>16</td>
<td>21</td>
<td>76.2%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

There was an identified medical safeguarding children lead. However medical and dental staff within the children and families service did not meet any of the four trust targets for completion of safeguarding training. We requested information from the trust on the number of staff compliant with safeguarding children level 4 training. In line with the Intercollegiate Document, level 4 training is required for staff involved in the investigation process of suspected abuse. However, the trust did not provide any information on the number of medical staff required to be level 4 trained, or the current compliance with this.

Nursing and midwifery staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff last year</th>
<th>% Completion</th>
<th>Trust Target (%)</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection Level 1</td>
<td>513</td>
<td>542</td>
<td>94.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Child Protection Level 2</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child Protection Level 3</td>
<td>433</td>
<td>507</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>503</td>
<td>542</td>
<td>92.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff met the trust target for three of the five safeguarding training courses made available to them. It should be noted that the safeguarding children level two training course compliance achieved above the trust’s own target in line the currently available data on average comparative national trend target.

(Source: Routine Provider Information Request (RPIR) – Training tab and Trust data return DR2, DR4 and DR11)

For this group of staff, the trust told us that all of the staff that required level four children’s safeguarding training (six nursing staff in total) had completed the required safeguarding training to be level four compliant, in accordance with the Intercollegiate Document.
Several staff commented that training throughout the trust had become better organised over the previous 12 months.

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority had its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Trust wide, community health services made 521 safeguarding referrals between January 2017 and December 2017, of which 125 concerned adults and 396 concerned children. However, as the trust had not provided a breakdown by core service or by individual service, we were unable to identify the number made by services for children and young people.

<table>
<thead>
<tr>
<th>Referrals</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults</td>
<td>Children</td>
<td>Total referrals</td>
</tr>
<tr>
<td>125</td>
<td>396</td>
<td></td>
<td>521</td>
</tr>
</tbody>
</table>

Looking across the 12-month period, child referrals saw a general upward trend with peaks in July (46) and November (45).

(Source: Routine Provider Information Request (RPIR) – Safeguarding referrals tab)

The trust had a children’s safeguarding team in place. We found this team supportive of other staff across the trust and knowledge about their role. They provided examples of support given to staff. For example, the safeguarding team attended any court hearings with staff to provide support and provided support in the writing of statements and reports for legal proceedings.

However, we found that communication with other organisation and professionals cumbersome and posed a risk to child and young people who had been referred to the multiagency safeguarding hub (MASH). For example, the electronic systems used by individual agencies did not communicate with each other. The safeguarding team provided an example of when evidence was not shared by an organisation which may have prevented further harm in a domestic violence case.

All health visiting staff we spoke with were aware of the safeguarding children policy. There was a clear process for staff to follow in the event a safeguarding referral needing to be made. Some staff we spoke with were aware of the process and could describe examples of safeguarding referrals they had been involved in or been told about. They could also describe the type of circumstances when a referral should be made. Safeguarding issues were discussed at team, team leader and operational manager meetings, if relevant to the service. We saw evidence that safeguarding was part of the agenda within health visiting team meetings.

There were systems to identify whether children were subject to a child protection plan. For example, an alert could be placed on a child’s record using the trust’s electronic patient record system. When accessing a child’s record, the child protection plan details could be reviewed by clicking on the alert. We saw this alert system being used during our visit.
Staff within some teams had access to specific safeguarding training on female genital mutilation, child sexual exploitation and domestic violence. Staff within the health visiting service told us they considered the range of training and information available was good and was easily accessible.

There was a gap in the safeguarding arrangements in place for assessing need and providing early help within the health visiting service. At the time of our inspection, the antenatal visit, which was one of the five key contacts within the healthy child programme, was not routinely being carried out. As a result, health visitors were relying on the knowledge of midwives and GPs to assess whether there was cause for concern regarding the women they were not visiting.

The health visiting service was prioritising antenatal visits to first-time mothers and when a cause for concern was raised by midwives and/or GPs. The first time health visitors were seeing most mothers was at the new birth visit. This was a potential risk as any assessment in relation to a mother’s and/or child’s vulnerability to abuse or environment was delayed.

The trust began to manage this through the divisional risk register in May 2018, however when we raised this issue with the trust after our inspection visit it became clear their data had created a misleading picture of the risk. This did not effectively support the need to address a strategy.

**Specialist services for children**

We found the children in care team’s oversight of the most vulnerable children and young people was not robust. Staff in this team told us they were unable to follow up on those most at risk; children and young people (such as those who had experience child sexual exploitation, female genital mutilation (FGM) and unaccompanied child refugees). The team relied on other services such as GPs and school nurses to monitor the health of this group of children and young people. The children in care team did not have the resource to follow up on any children and young people that were not registered with or attended other settings such as school.

Staff within the school nursing service told us they received separate safeguarding supervision on a six-monthly basis with the safeguarding nurse within the trust. The supervision was used to discuss safeguarding cases and steps or actions to be taken. They also confirmed there was a dedicated safeguarding lead nurse within the school nursing service who they could contact for additional advice or support. The staff also confirmed they received regular feedback on safeguarding referrals from the trust and the local authority.

We found not all complex care staff had a clear understanding of safeguarding issues. We passed this on this to the divisional nursing manager who gave us assurance action would be taken to improve this.

Nurses we spoke with in the short break service described a range of contacts and support available to them, including the on-duty manager phone line, the multi-agency safeguarding hub (MASH) or the social care managers. They told us the trust’s safeguarding policy and procedures were on the intranet for them to access. However, when we asked to see these there was only a policy document available and we have already outlined its shortfalls above.

**Cleanliness, infection control and hygiene**

The service did not always manage control of infection risk well. They used control measures to prevent the spread of infection but not all staff kept themselves, equipment and the premises clean.

At our last inspection in 2014 we said that appropriate decontamination processes and infection prevention audits should be put in place to promote and monitor improvement in practice. During the 2018 inspection we found general improvement but some variable practice in some parts of the service.
There were reliable systems in place to prevent and protect people from a healthcare-associated infection. Safety systems, processes and practices were developed, implemented and communicated to staff to ensure the safety of patients. Within the trust there was infection prevention and control team who were responsible for ensuring the trust's practices, related to infection prevention and control (IPC), were safe. The trust told us this team’s objective was to engage staff at all levels to develop and embed a culture that supported infection prevention and control across the organisation. The team also audited services within the trust in respect of IPC practice and reported their findings to the trust board.

Universal services for children
We saw within the school nursing service nurses wore uniform which included short sleeve tunics/dresses that meant arms were bare below the elbow as per trust policy for infection control. However, we found staff within the health visiting service were not always complying with the policy. The clinic environments we visited, used by the health visiting service, were visibly clean and clutter free. We saw most health visitors and assistant practitioners washing their hands before and after contact with children. We also saw weighing scales and changing mats wiped after every use. However, not all staff washed their hands between patient contacts, not all were bare below the elbow, some wore jewellery/nail varnish and staff did not always use appropriate protective equipment to carry out procedures. For example, staff told us that they did not always use aprons when emptying clinical waste bins. We also saw staff opening pedal operated bins with their hands and then touching furniture before washing their hands.

Compliance with infection prevention and control mandatory training within services for children and families was above the trust target. However, the health visiting service did not regularly audit its compliance with the trust’s infection prevention and control policy, procedures and practices. An annual infection prevention and control audit had been carried out by the infection prevention and control team in 2016-2017 but there was no reference to the health visiting service. Team leaders, health visitors and assistant practitioners told us audits relating to infection prevention and control were not carried out and they had not seen recent data related to their performance. Infection prevention and control was not routinely discussed in senior management governance meetings but when it was an item, there was no detail on what was discussed.

The arrangements for the availability of personal protection equipment were not always effective at clinics where health visiting teams operated. We saw gloves and aprons were available at the clinics we visited but staff said there was no system to ensure they were always available. Staff said they have been in locations where cleaning wipes weren’t available and so needed to telephone for an urgent delivery.

We raised these issues with the trust during our inspection and they sent us a plan of action for improving consistent good practice.

Specialist services for children
We found cleanliness standards were maintained at both child development centres (CDC) we visited. For example, floors were visibly clean, as were kitchen areas and toilets. We observed staff in clinical areas complying with the ‘arms bare below the elbows’ guidance, reducing the risk of cross infection.

However, staff at one CDC informed us that they no longer submitted hand hygiene audits and were unsure when these were last undertaken. We requested the last two hand hygiene audits from all the trusts CDCs but the trust responded only by assuring us ‘hand washing is covered in the annual IPC update training’. The CDCs had full compliance with mandatory infection prevention and control training.’ This means the trust could not assure itself staff were practicing effective hand hygiene practices and that it was effective.

At the CDCs we observed all toys and equipment were cleaned with antibacterial wipes at the end of the session.

The trust provided the last two hand hygiene audits for the only overnight facility it provided for children at Turtles at Edgewood Road. This service accommodated up to six children at a time for short breaks. Managers at this service told us they audited the hygiene standards of the facility like
a ward. The hand hygiene audits for November 2017 and March 2018 were limited to assessing staff working with one patient on each occasion. The trust did not provide the overall score for November 2017 audit. In March, the staff member observed with the patient achieved full compliance for hand hygiene. In the residential service there were dispensers appropriately sited on walls containing hand sanitiser for staff and visitors to use.

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.** Premises and equipment shared with other providers were not always well looked after.

The design, maintenance and use of facilities and premises used solely by the trust were suitable for purpose. There were some compromises in standards within premises owned by other providers but used by the trust to achieve localised delivery of services to people. There were effective arrangements for managing waste.

**Universal services for children**

All environments we visited, within the health visiting service, were suitable for the delivery of patient care. We saw corridors were uncluttered with equipment and trollies were stored away safely. Waste was segregated appropriately with separate waste bins for both general and clinical waste.

The maintenance and use of equipment was mostly, but not always checked and serviced. In the health visiting service we looked at a variety of equipment in four different clinics and found all servicing was up to date apart from two weighing scales, both of which were due for service in February 2018. Team leaders held records for the equipment within their teams, which identified whether it was in use and when it was due to be serviced.

Equipment was stored appropriately. For example, all equipment used by the health visiting service was stored on shelves off the ground and storage areas were visibly clear and free of dust.

**Specialist services for children**

When we visited Park House CDC we noted a lack of suitable storage for equipment. The physiotherapy room had large pieces of equipment stored awaiting removal. Staff told us this reduced space and made it difficult to undertake physiotherapy sessions. We found a variety of equipment stored within the children’s bathroom, including electronic equipment and soft toys stored in front and on top of a radiator. The equipment was not stacked safely and was a safety hazard to anyone who used the bathroom. We raised this with local managers who assured us they would deal with it.

There were hand wash sinks in clinical areas. We found the sluice room at Park House CDC unlocked and accessible. The floor was uneven, and we noticed on several occasions the door open due to catching on the uneven floor. We found chemicals left out and accessible, and the cleaning fluids store cupboard unlocked, open and with the key in the lock. This is not in line with the Control of Substances Hazardous to Health (COSHH) Regulation 2002 and posed a risk to young children. The trust’s COSHH policy (updated March 2017) stated all hazardous substances should be stored in accordance with approved codes or practice or official guidance and manufacturers guidelines.

At Allens Croft CDC, which is a shared multi-agency building, we found consulting and treatment rooms with carpeted floors, including four consulting rooms, one occupational therapy room, the play therapy room and one physiotherapy room. Following the inspection, the trust told us of a further four rooms across all the CDCs that had carpeted flooring. We spoke with the trust’s estates and facilities managers about buildings the trust shared with other providers. They told us they were working with landlords to remedy this.

However, the trust provided an audit of Allens Croft CDC undertaken in June 2017. This identified carpet within consultation rooms. No actions had been taken to mitigate the risks to infection control while negotiations were continuing with landlords and we have not been assured about this.
We requested information regarding the cleaning of carpeted floors, particularly after bodily fluid spills. The trust provided the cleaning policy; however, this was a draft policy written in 2015. During a follow up inspection, we found the draft version was available to staff on the intranet; however, this was a draft and had not been updated since publication in 2015.

The trust’s standard infection control precautions policy did not state how to safely clean carpeted areas following body fluid spillage. We have asked the trust to act quickly to more effectively control this risk.

We checked three pieces of clinical equipment at the CDCs visited and found all had been serviced within the last year and had next service date stickers attached.

Staff we spoke with told us that there were issues with accessing the weight room in CDC. We spoke with the trust’s estates and facilities managers about buildings the trust shared with other providers. They told us a checklist system was in place for the trust’s services local managers to assess the environment in which services were provided. This included accessibility. Where any room scored a negative against any point the service should contact the trust’s estates management help line and they would work with landlords to remedy this.

The estates manager we spoke with had not been made aware of the problem of inaccessibility in this weight room. The trust has undertaken to assess and manage access to this room and equipment.

At the short break service, we saw children’s bedrooms had individually themed décor. This was an improvement from our last inspection. Staff told some children had favourite rooms that they liked to stay in.

Children’s rooms had beds specific to their assessed needs when they were booked in. The service had two ‘sleep system’ kits used to aid postural alignment at night. The trust confirmed all of their staff that work in this service were trained in sleep systems as of Friday 18 May 2018. The environment was spacious, visibly clean and uncluttered, yet child friendly. It was designed to meet the needs of the children who used it and rooms were themed on fashionable children’s culture icons.

Inclusion services for children
In a special school we observed physiotherapists from the trust’s inclusion service providing services to children. The room used, provided by the school, was overcrowded with equipment and equipment storage space was very cramped.

Assessing and responding to patient risk

Universal services for children
The trust contributed to delivery of the national healthy child programme for the early life stages. This focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

We saw evidence during our inspection visits of the health visiting service, where appropriate, comprehensive risk assessments were carried out and risk management plans were developed in line with national guidance.

We saw children and their families were risk assessed for safeguarding issues, parental mental health and general health. Where required, risks were managed appropriately, for example, when mothers were identified as having possible post-natal depression, they were signposted to services where they could receive the additional care and treatment they required.

We saw evidence during our inspection visit of risks to patients and those close to them were assessed, their safety monitored and managed so they were supported to stay as safe as practicable. Staff used their professional judgment and called on others to identify and respond appropriately to changing risks. This included deteriorating health and wellbeing. Staff could seek
support from senior staff in these situations and we saw multiple examples of this across the health visiting teams.

The healthy child programme was designed to identify children, young people and families according to their level of need. The level of service delivered to children and their family aimed to be dependent upon need and the assessed risk of harm. An alert system was in place within the health visiting service to record and indicate specific risks, such as domestic abuse. There were pathways for staff to follow when risks were identified.

However, staffing issues within the health visiting teams meant the trust was delivering antenatal visits, one of the key national performance indicators, on the basis of risk assessment only. We found team leaders within the health visiting service did not always have oversight of staff caseloads. Staff within the health visiting service held responsibility for ensuring all their active cases were recorded on a team spreadsheet. If staff did not record their active cases on the spreadsheet, team leaders would not know how many active cases were on the team caseload or what type they were.

We saw evidence where a health visitor had not recorded all of their active cases on their team spreadsheet. As their team leader had no oversight of the cases there was no other opportunity to review or challenge the health visitor’s decisions. We continue to be in contact with the trust over this matter.

Specialist services for children

The complex care team (CCT) did not undertake specific training in relation to the deteriorating patient. However, the trust told us that recognition of deterioration was included in each individual competency that support workers undertook on each child or young person.

All staff undertook basic life support training for children and young people. Support workers undertook additional resuscitation training where they looked after ventilated patients or those with a tracheostomy. Staff we spoke with supporting children during their school day confirmed this.

Nurses at the short break service told us the children’s community nurse on call system was very helpful for them for ‘trouble shooting’ medical issues, for example gastro intestinal tube infection.

Special school nurse managers told us all school nursing staff were undertaking tissue viability training. A nurse had recently identified sepsis in a child at school which meant urgent medical action was taken to protect that child.

Nursing staff completed care plans for each need for example, toilet requirements, enteral feeding and tracheostomy care, for each individual child or young person. However, we found the trust did not have care plans for ventilation care for some children. We found each child had an overview of the ventilation care given with the required pressures, but no detailed care plan to guide staff should the ventilator stop working or the child or young person become unwell. We raised this with the trust and they sent us an urgent assurance plan for addressing this.

The results from the trust’s 2017/18 audit showed: only 58% of care records sampled in the children’s and families’ division clearly listed information on hypersensitivities / allergies. Entries made by a staff member who required them to be validated by a different member of staff within timescales required by the service, fell below the trust’s target compliance rate (85%) at 74%. This indicated oversight could be lacking to control risk of error.

A serious incident report in April 2018 showed nursing staff at the short break service had responded and successfully resuscitated a young person while the emergency ambulance service was on its way.

Staffing
The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Safer Staffing levels

We found staffing levels were a concern in most areas across the children and family’s division services. We raised this with the trust and they assured us they had an active programme of ongoing recruitment for nursing staff but struggled to attract applicants. We have asked for further assurances over the trust’s management of this issue.

Universal Services for children

Maximum and optimum caseload size within the health visiting service was directed by team leaders but it was unclear whether they were based on national benchmarking and evidence/recommendations from national professional bodies. The Community Practitioners and Health Visitors Association (CPHVA) recommend an optimum average caseload, for safe and effective practice of 250.

Health visitor caseloads were above the recommended levels in most teams within the service. Some team leaders told us a maximum caseload of 370 had been set. However, the maximum caseloads differed within each team and most team leaders and staff we spoke with told us caseloads exceeded 370, with some health visitors having caseloads of between 440 and 500. We saw data from January 2018 which confirmed average caseloads per whole time equivalent were in the region of 500 and therefore significantly above the nationally recommended levels.

Health visitor caseloads included children who were receiving universal, universal plus and universal partnership plus services. We were told health visitors should only have between 30 and 40 universal plus and universal partnership plus cases but this was not always the case. Health visitors told us their caseloads would often contain more than 40 cases. Team leaders could monitor individual health visitor caseloads using the caseload monitoring tool. This was used to review how many safeguarding cases a health visitor had and could be broken down to look at specific safeguarding issues. For example, the number of cases related to mother’s mental health, child protection and domestic abuse.

The health visiting service had arrangements to plan and allocate caseloads. Each health visiting team had a weekly allocation meeting, where new referrals would be discussed and allocated to health visitors depending on capacity. All staff we spoke with said the system was effective as it gave individual staff the opportunity to discuss their capacity and be allocated work based on their current caseloads. Managers told us there were teams within the health visiting service that were at full capacity and could not allocate all referrals they received. As a result, referrals received by some teams were transferred to other teams who had capacity.

Several staff within the health visiting team told us they regularly had to work over their contracted hours due to low staffing levels. They said they did not claim this time back as it would only cause additional capacity issues for their teams.

The health visiting service had quarterly “shut down” days where visits were not planned to enable staff to review their entire caseload to ensure care plans were progressed.

Specialist services for children

For the children in care team (CiC) we found the trust was not meeting the Royal College of Paediatric and Child Health (RCPCH) 2015 guidance or its own targets on safer staffing.

<table>
<thead>
<tr>
<th>Whole Time Equivalent (WTE) Registered Staff</th>
<th>Total Case Load Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2</td>
<td>1940</td>
</tr>
</tbody>
</table>
This equated to approximately 600 children or young people per WTE practitioner. The RCPCH 2015 suggested 100 children or young people per WTE practitioner.

The CiC team told us, due to the size of caseloads and numbers of staff available they were unable to provide the care and ongoing health support needed for some children and young people, particularly those most at risk. Staff gave examples of children and young people who had been sexually exploited or have arrived unaccompanied into the UK as refugees and have been placed in a children’s home. The CiC team told us they were unable to provide the support to these groups of children and young people. We have asked the trust to take action to review this matter.

Within the ‘inclusion services’ staffing, which includes occupational therapy, physiotherapy and speech and language therapy, we found the following whole time equivalent staff and open caseloads:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Unregistered Support staff</th>
<th>WTE Registered Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and language</td>
<td>7.35</td>
<td>37.08</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>12.84</td>
<td>19.8</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>0.6</td>
<td>7.69</td>
</tr>
</tbody>
</table>

Caseload sizes:

<table>
<thead>
<tr>
<th>Service</th>
<th>Total open referrals to service</th>
<th>Patients not yet seen</th>
<th>Patients who have had one or more appointments</th>
<th>Number waiting between assessment and treatment starting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Development Centre</td>
<td>1343</td>
<td>623</td>
<td>587</td>
<td>133</td>
</tr>
<tr>
<td>Speech and language</td>
<td>4792</td>
<td>2151</td>
<td>1913</td>
<td>728</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>1739</td>
<td>1089</td>
<td>340</td>
<td>310</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>3092</td>
<td>544</td>
<td>2147</td>
<td>401</td>
</tr>
</tbody>
</table>

The complex care team (CCT) was made up of clinical support workers and registered nurses. During our inspection visit, one of the team leaders we asked was unable to provide information on the number of WTE support workers within the CCT. However, the trust told us following our visit that they had the following staff:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Actual Whole Time Equivalent</th>
<th>Funded Whole Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Leader</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Senior Staff Nurse</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Medical Device Nurse Specialist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>4.6</td>
<td>6.6</td>
</tr>
<tr>
<td>Support Workers</td>
<td>74.66</td>
<td>76.66</td>
</tr>
</tbody>
</table>

One team leader told us they had 61 children or young people currently receiving packages of care. The trust last undertook a workforce review of the complex care team in 2013. During our inspection visit, two senior nurses within the CCT told us that the support staff were currently
employed at ‘agenda for change’ Band 3 level. However, the work they were expected to undertake was equivalent to Band 4. No review of the skill mix in relation to ‘agenda for change’ had been undertaken since 2013.

The complex care team staffed an on-call system 24 hours a day by a registered nurse to provide support and guidance to support workers and parents or carers. The on-call nurse would provide both telephone and onsite support. The trust provided audit information that showed the number of calls made to the on-call nurse during a one-week period in April 2018.

The five most frequent reasons for calling the on-call nurse are shown below. It is notable by far the highest frequency of contact was from staff about urgent rota alterations and the lower frequency of contact was for clinical reasons.

<table>
<thead>
<tr>
<th>Reason</th>
<th>In Hours (8am to 4pm Monday to Friday)</th>
<th>Out of Hours (4pm to 8am Monday to Friday and all-day Saturday and Sunday)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rota alterations – urgent within 24hrs – from staff</td>
<td>18</td>
<td>83</td>
</tr>
<tr>
<td>Rota alterations – non-urgent more than 24 hours – from staff</td>
<td>12</td>
<td>51</td>
</tr>
<tr>
<td>Rota alterations – urgent within 24 hours – from parent</td>
<td>8</td>
<td>23</td>
</tr>
<tr>
<td>Clinical Concern – urgent – from staff</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>Rota alterations – non-urgent more than 24 hours – from parent</td>
<td>0</td>
<td>32</td>
</tr>
</tbody>
</table>

### Vacancies

From January 2017 to December 2017, the trust reported an overall vacancy rate of 7.4% in community services for children and families, compared to an overall trust target of 9%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (including admin &amp; clerical)</td>
<td>783</td>
<td>9.5%</td>
</tr>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>703</td>
<td>9.3%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>439</td>
<td>7.9%</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>1,723</td>
<td>7.4%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>1,063</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td><strong>4,712</strong></td>
<td><strong>7.4%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

### Universal services for children

Staffing levels and skill mix were planned and reviewed so that people receive safe care and treatment. However, staffing within the health visiting service was considered a major risk. Team managers told us they had raised staffing levels within teams as incidents on the trust’s electronic reporting system when they were considered a safety risk.
According to recent data provided by the trust, there were almost 33 whole time equivalent health visitor vacancies within the health visiting teams. This amounted to a 14% vacancy rate which was above the trust target of nine percent. The service was doing the following to address staffing issues:

- Staff had been moved between teams on a temporary basis to support teams with the most significant staffing issues.
- Operational managers were reviewing staffing across the service on a weekly basis.
- Information regarding priorities regarding health visitor contacts had been cascaded to the service.
- Managers were increasing their visibility to team leaders and teams to provide ongoing support and advice regarding workload and caseload management.
- Active recruitment resulted in 16 health visitors being offered posts in the summer of 2017 and was currently ongoing.

Staffing levels were impacting the health visiting service’s performance as it meant prioritising some contacts with children and mothers over others. For example, the antenatal visits were not always taking place due to lack of health visitor capacity.

The health visiting service was undergoing a restructure at the time of our inspection, which would result in the health visiting service being redesigned to align teams to council districts instead of GP practices. As part of this restructure, assistant practitioner posts were going to be reduced significantly. The work carried out by assistant practitioners was going to be absorbed by health visitors and family support workers, who were being trained at the time of the inspection. Staff told us they were worried that the work currently undertaken by the assistant practitioners would be allocated to health visitors, who were already had limited capacity.

Specialist services for children

Vacancies in the community paediatrician’s team were an item on the division’s risk register. The trust told us locum arrangements were in place until December 2018.

The complex care team was short of two full time equivalent (FTE) staff nurses, this represented one third of its allocation. The trust was managing this by adding two further support workers to the team. However, this would not address the skills and supervision shortage created within the team by these vacancies.

In March 2018 the risk register for the division identified that nursing shortages at the short break service, could prevent children receiving their short breaks beyond 7 May 2018.

The trust was a health contributor to this service and contracted to provide a qualified nurse on duty for each shift when children are present at the service. Local leaders told us these vacancies were due to an inability to recruit appropriately qualified and experienced staff or ‘engage outside support for bank or agency staff’. The trust was managing the risk by not admitting children whose medical needs could not be met by competent social care workers, on duty within the service and employed by another stakeholder.

When we visited the service on 23 May 2018 there was a qualified nurse on duty for each shift of that day. Nurses we spoke with confirmed the staffing levels were managed safely with the support of social care staff on site. The service manager told us the service was closed over the forthcoming spring bank holiday weekend because of nursing staff shortage. However, all children had already had their contracted ‘offer’ of service during the month of May 2018.

Since the risk had been identified and escalated to the register, the trust had better success at recruitment and a further Band 6 and Band 5 nurse were taking up posts.

Turnover
From January 2017 to December 2017, the trust reported an overall turnover rate of 8.4% in community services for children and families, compared to an overall trust target of 12%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (including admin &amp; clerical)</td>
<td>86</td>
<td>14.1%</td>
</tr>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>260</td>
<td>10.3%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>34</td>
<td>6.4%</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>478</td>
<td>3.7%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>118</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td><strong>976</strong></td>
<td><strong>8.4%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness**

From January 2017 to December 2017 the trust reported an overall sickness rate of 5.7% in community services for children and families. The trust did not have an overall sickness target, but instead had a monthly target which recognised seasonal trends. Therefore, we were unable to comment on comparative sickness performance for staff in children and families services.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>7,926</td>
<td>6.2%</td>
</tr>
<tr>
<td>NHS infrastructure support staff</td>
<td>3,607</td>
<td>6.1%</td>
</tr>
<tr>
<td>Nursing and health visiting Staff</td>
<td>14,507</td>
<td>6.0%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>2,611</td>
<td>2.8%</td>
</tr>
<tr>
<td>Medical and dental Staff</td>
<td>1,025</td>
<td>2.7%</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td><strong>29,676</strong></td>
<td><strong>5.7%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Nursing – Bank and Agency Qualified nurses**

From January 2017 to December 2017, the trust reported an overall bank and agency usage rate of 29.8% for qualified nursing staff.

<table>
<thead>
<tr>
<th>Total number of shifts available</th>
<th>Total shifts Filled by bank staff</th>
<th>% Usage of bank staff</th>
<th>Total shifts filled by agency Staff</th>
<th>% Usage agency staff</th>
<th>Total shifts NOT filled</th>
<th>% of shifts not filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,767</td>
<td>1,191</td>
<td>25%</td>
<td>227</td>
<td>4.8%</td>
<td>205</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Nursing bank agency tab)*

**Nursing - Bank and Agency Healthcare Assistants**

From January 2017 to December 2017, the trust reported an overall bank and agency usage rate of 95.2% for healthcare assistants.
<table>
<thead>
<tr>
<th>Total number of bank/agency shifts available</th>
<th>Total shifts filled by bank staff</th>
<th>% Usage of bank staff</th>
<th>Total shifts filled by agency staff</th>
<th>% Usage agency Staff</th>
<th>Total shifts NOT filled</th>
<th>% of shifts not filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,365</td>
<td>3,142</td>
<td>93.4%</td>
<td>63</td>
<td>1.9%</td>
<td>73</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

In comparison, the trust-wide bank staff usage for nursing assistants was 46.9%, while the overall bank usage for nursing assistants in community adults was 32.3.

(Source: Routine Provider Information Request (RPIR) – Nursing bank agency tab)

Medical locums

From January 2017 to December 2017, 357 (100%) were filled by agency staff across the entire core service.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Consultant cover

The trust had advised that for community services for children and families acute paediatric on call cover was not provided and there were no paediatric in-patient beds. But community paediatrics offered a 24/7 service for the Sudden Unexpected Death in Childhood (SUDIC) service in Birmingham and contributed to the West Midlands Paediatric Sexual Assault Service (PSAS). For both services the grade of doctor is a consultant. The SUDIC on call doctor was accessed via Birmingham Children’s Hospital switchboard and PSAS service via G4S switchboard.

A 9am - 4pm Monday to Friday service was provided in relation to child protection medicals for children with concern about physical abuse/neglect.

(Source: Routine Provider Information Request (RPIR) – Consultant cover tab)

Managers at the central booking service for clinics such as paediatric community physiotherapy, occupational therapy, speech and language therapy and Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ADS) (Inclusive Services) told us there was a high staff turnover, high rates of sickness, and absence from maternity leave. The system we observed in place of operators specialising in one type of clinic booking only, further strained its flexibility to respond to demand. Managers told us they had plans to address this lack of flexibility within new funding allocation from the Clinical Commissioning Group (CCG’s) for reducing the back log of follow up appointments.

Suspensions and supervisions

From January 2017 to December 2017, the trust reported that there were five cases where staff had been either suspended or placed under supervision in services for children and families. One member of staff had been suspended, one was placed under restricted practice and three were under supervision.

Quality of records

Staff did not always maintain the appropriate records of patients’ care and treatment. Records were clear and available to all staff providing care but they were not always up-to-date.
Systems were in place to ensure information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way. However, the effectiveness of systems was reduced by a high level of gaps and omissions in some patients' records. The trust provided assurance that learning from its 2017/18 records audit was shared across some local teams and improvement plans implemented, although the score had showed a deteriorating trend from 2016/17.

Universal services for children
Staff spoke about how the integrated electronic patient record enabled improved access to information across disciplines. For example, referrals to other professionals occurred quicker and information was accessible to all staff as needed. During our inspection visits we saw how referrals from the health visiting service could be made to other services within the trust and how health visitors could check on their progress. This enabled staff to assess information quickly and provide parents with up to date information.

However, we found shortfalls in some patient’s records, including items that had already been identified as needing improvement by trust internal audits.

The trust reported it undertook audits of records in 2016/2017 and 2017/2018. The children and families division conducted an audit, which excluded the universal children’s services as they undertook their own. The children and family division audit focussed on 40 areas of compliance with a target of 85% overall and 85% per question asked. We did not review the audit for universal children’s services.

In the 2016/17 audit, the children and family’s division achieved 82% overall, which was below the target. In the latest 2017/18 audit, the results were worse, with the children and family’s division achieving 78% overall compliance. The results from the 2017/18 audit that did not achieve the 85% target were:

<table>
<thead>
<tr>
<th>Question / Measure</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is information on hypersensitivities / allergies clearly listed?</td>
<td>41.6%</td>
<td>58.4%</td>
<td>---</td>
</tr>
<tr>
<td>Is the name of the key person to contact in the event of an emergency present?</td>
<td>79.2%</td>
<td>20.8%</td>
<td>---</td>
</tr>
<tr>
<td>Is it clear from the clinical record who is the person the patient has consented for staff to link in with to share information about their health, care and treatment?</td>
<td>21.21%</td>
<td>10.82%</td>
<td>67.97%</td>
</tr>
<tr>
<td>(66.2% of applicable)</td>
<td></td>
<td>(33.7% of applicable)</td>
<td></td>
</tr>
<tr>
<td>In the last 5 entries if treatment was provided do the notes record whether the patient or their designated representative gave valid informed consent to treatment or declined treatment?</td>
<td>26.84%</td>
<td>22.08%</td>
<td>51.08%</td>
</tr>
<tr>
<td>(54.9% of applicable)</td>
<td></td>
<td>(45.1% of applicable)</td>
<td></td>
</tr>
<tr>
<td>In the last five entries if care and treatment required written consent to be obtained was this obtained and documented using correct consent form?</td>
<td>7.79%</td>
<td>4.33%</td>
<td>87.88%</td>
</tr>
<tr>
<td>(64.3% of applicable)</td>
<td></td>
<td>(35.7% of applicable)</td>
<td></td>
</tr>
<tr>
<td>Where the last five entries indicate staff were communicating with someone other than the patient does the record indicate the name of the person staff were talking to and their relationship to the patient?</td>
<td>54.98%</td>
<td>26.84%</td>
<td>18.18%</td>
</tr>
<tr>
<td>(67.2% of applicable)</td>
<td></td>
<td>(32.8% of applicable)</td>
<td></td>
</tr>
<tr>
<td>Have all entries made by a staff member who requires them to be validated by a different member been validated within timescales required by the service (answer ‘no’ if there were no invalidated entries)?</td>
<td>26.03%</td>
<td>73.97%</td>
<td>---</td>
</tr>
<tr>
<td>Have all entries made by someone who is required to have entries countersigned been appropriately countersigned?</td>
<td>57.1%</td>
<td>42.9%</td>
<td>---</td>
</tr>
</tbody>
</table>

Patients NHS number present (each side of every page)? | 80.5%  | 19.5%    | ---            |
Are there any gaps present in the record? 51.2% 48.8% ---

If ‘yes’ are the gaps in the record dealt with in line with trust record keeping policy? 72.9% 27.1% ---

Are any corrections within the record dealt with in line with trust clinical record keeping policy? 69% 31% ---

<table>
<thead>
<tr>
<th>Question / Measure</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (all entries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many of the last five entries had time in the 24 hour format?</td>
<td>8.82%</td>
<td>10.78%</td>
<td>7.35%</td>
<td>10.78%</td>
<td>16.18%</td>
<td>46.08%</td>
</tr>
<tr>
<td>How many of the last five entries have printed full name and designation of the</td>
<td>6.93%</td>
<td>7.92%</td>
<td>7.43%</td>
<td>8.42%</td>
<td>6.93%</td>
<td>62.38%</td>
</tr>
<tr>
<td>staff member?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many of the last five entries had a staff member’s signature?</td>
<td>0%</td>
<td>1%</td>
<td>1.49%</td>
<td>3.48%</td>
<td>10.45%</td>
<td>83.58%</td>
</tr>
</tbody>
</table>

We requested the action plans relating to the last records audit. The trust provided specific action plans for two school nursing teams and one health visiting team. However, despite the deteriorating trend from 2016/17, the trust could not provide us with any action plans for other teams, or generic improvement plans for all teams to follow.

We found not all records in the health visiting service were as up to date as they could be. The trust had a policy which stated patient records must be completed within 24 hours following a patient contact which, most staff in service said they were compliant with. Most staff updated the electronic records shortly after seeing a patient and we saw this practice during the inspection. Some staff told us record entry could be delayed due to annual leave.

**Specialist services for children**

The integrated electronic patient record had not yet been rolled out to specialist services at the time of our inspection. The trust said it intended to do so when the improvements identified through the universal services pilot were addressed.

We looked at six sets of paper patient records from the complex care team. We found all records had been reviewed by a registered practitioner within the last 12 months. We found risk assessments present in patient’s records were up to date and reflected the assessed needs of the patients.

However, we found the following omissions in one or more of those records:

- Staff did not sign and print their name and include their role or designation
- Support worker entries were not countersigned by registered nurse
- Allergies were not clearly recorded in all cases

This concurred with the trust’s audit and demonstrated the shortfalls identified by the trust’s audit had not been addressed.

We looked at eight sets of nursing care records at the short break service, a service where children had overnight stays. These covered a range of risk assessments, personalised care plans and notes written for each shift of care for the child. They were legible, informative and up to date and most were dated. However, not all files were organised in the same way through the file sections and this could make it difficult for staff, particularly new or agency staff to access information quickly. The manager told us each child’s notes were currently being audited. There was no audit checklist at the front of the files we saw.
Medicines

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

Universal services for children
With the health visiting service, at most locations we visited, medicines were appropriately stored in lockable cabinets. Storage facilities were visibly clean and tidy.

Within the health visiting service children and parents were offered vitamins by health visitors. If vitamins were provided to children or parents, health visitors were required to complete a sheet recording what had been given, and who to. We observed varying practice in relation to this during clinics. We noted this had been recognised as an issue in some teams as it had been raised in team meetings. We also saw that batch numbers and expiry dates were not noted on the sheet.

Specialist services for children
Turtles short break service had recently introduced a ‘green PE bag’ scheme to enable children using the short break service and attending special schools, to take their medications with them as they moved between services during their day and week. Staff told us this had already shown a reduction in medication errors and doses missed, if the medication was elsewhere at the time it was needed. We saw these bags were kept securely in the clinic room at the special school we visited. We also saw children’s medication stored in locked individual named drawers bearing the child’s photograph and at the short break service.

Health care assistants told us they were ‘signed off’ as competent to administer the lunch time medication of the child they supported at school. They confirmed each child’s medication was locked securely in the school nurse’s medication cupboard at the school each morning.

The trust’s own evaluation in March 2017 of the mechanisms in place for medicine management in Staffordshire special schools where shared responsibility is in place reported special schools and school nurses had good systems in place for medication management.

We observed a medication round at a special school. Two nursing/support staff were present and medications, current dosage and the identity of the child was checked before administration. Where medication was administered through a gastro intestinal tube, we heard nurses make a clear explanation to the child and gain the consent of young people. A second carer was present to calm and reassure the child during administration of the medication.

Support staff confirmed they could apply topical medications such as creams to children according to their care plan. They told us they had completed training provided by the school nurses to do this for an individual child/young person.

Safety performance

Safety Thermometer

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are ‘harm free’ during their working day. For example, at shift handover or during ward rounds. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient’s own home, to measure, assess, learn and improve the safety of the care they provide. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

Please note, the figures reported for pressure ulcers, catheter induced urinary tract infections and falls are not the total number reported, but are the numbers reported from a sample of 100 patients per month.
We saw the short break service Turtles at Edgewood Road, to which the trust is a health contributor, had a ward safety dashboard on display. This displayed the figures for harm free care at the service. We noted the results displayed were positive for harm free care.

**New Pressure Ulcers**

From February 2017 to February 2018, the trust saw a prevalence rate of 3.3 pressure ulcers during the reporting period; this was the result in a spike in February 2018.

**Prevalence rate (number of patients per 100 surveyed) of new pressure ulcers at Birmingham Community Healthcare NHS Foundation Trust**

![Graph showing prevalence rate]

(Source: NHS Safety Thermometer)

**Catheter & UTI**

From February 2017 to February 2018, the trust reported no catheter induced urinary tract infections for community children and families services.

(Source: CHS Insight)

**Falls with Harm**

From February 2017 to February 2018, the trust reported no falls with harm for community children and families services.

(Source: CHS Insight)

**Incident reporting, learning and improvement**

The service did not always manage patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents but lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally, where appropriate. However, the trust did not always take into account the wider systemic issues that contributed to an incident and learning
from lessons was not always shared to ensure action was taken to improve safety. Leaders did not always understand the importance of staff being able to raise concerns and appropriate learning and action was not always taken as a result. Concerns raised by staff about their colleagues were not always investigated or acted on which impacted on the care delivered to children.

Universal services for children

We found staff within the health visiting service knew what incidents should be reported, the process for doing so and who to inform. Staff told us they would make their team leader aware of the incident and report it using the trust’s electronic reporting system. Staff told us reported incidents were received by operations managers who would then investigate.

Following a serious incident within the health visiting service, which occurred in April 2017, none of the staff we spoke with could tell us what the resulting learning was. Learning appeared to have been identified but there was no evidence it had been shared with any staff within the trust.

Specialist services for children

At Turtles, the only overnight bedded service for children, we saw that safety performance over time such as harm free days from falls and pressure ulcers were both monitored and displayed.

Two incidents, one categorised as a serious incident (SI) had been reported through the trust system and externally in March/April 2018. Both were under investigation at the time of our inspection. Early indications indicate that some agreed actions from investigation of the first incident (a near miss) were not proactively pursued in time to prevent the second more serious incident.

We noted evidence the trust had exercised its duty of candour appropriately after this incident, notified the next of kin that the incident has occurred, provided reasonable support to them in relation to the incident and offered an apology.

Within the special school nursing service, we saw recent examples of incident reporting on record and details of how the incident was investigated, what lessons were learned and how these were passed on to staff.

Never events reported to STEIS

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, there were no never events reported by the trust for community services for children and families.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in community services for children and families, which met the reporting criteria, set by NHS England, from February 2017 and January 2018. Both incidents were classified as administrative/IT errors.

(Source: Strategic Executive Information System (STEIS))
At the time of our inspection the trust had begun the investigation into the serious incident in the children’s short breaks service referred to above. The trust had reported this incident through the National Reporting and Learning System (NRLS), a central database of patient safety incident reports and STEIS and told the Care Quality Commission about it in a timely way.

The trust told us that a similar ‘near miss’ had occurred nearly four weeks before the serious incident. At the time of our inspection a root cause analysis (RCA) of the near miss was still underway. We asked the trust to send us the draft report. We noted what the trust sent us was an RCA that collated both incidents although they occurred almost a month apart. This could compromise the effectiveness of the learning. We are in ongoing contact with the trust about this matter.

We saw evidence where concerns had been raised on multiple occasions by staff about one of their colleagues. However, appropriate action was not taken.

**Prevention of Future Death Reports**

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been four prevention of future death reports sent to Birmingham Community Healthcare NHS Foundation Trust. One of these related to this core service, details of which can be found below.

1. **RCA Report - September 2017 [Regulation 28 Report]**

Unexpected death of child in school setting due to an anaphylactic reaction.

The Coroner’s concerns were:

- *Care plans are not in place for all pupils that require them.*
- *Delays in issuing care plans.*
- *All issued care plans had not been provided to the catering service by the school and communication between the school and the catering service in general is not effective.*
- *Inaccurate lanyards were used by children to identify which foods they were allergic to. The lanyard system has since been found to be not safe.*

(Source: Routine Provider Information Request (RPIR) – P86 – Prevention of future death reports)

At our last inspection of 2014 we said the trust should ensure that learning following serious untoward and never events is shared across all areas of the organisation. We found lessons learned following this incident were shared with staff to ensure action was taken to improve safety.

All school nursing staff were aware of the incident resulting in the unexpected death of a child due to an anaphylactic reaction. Staff we spoke with could describe the steps the trust had taken, which included delivering refresher training on the correct procedure to follow in the event of a child having an anaphylactic reaction and sourcing and sharing additional guidance with staff and the schools they worked in. The actions which caused the death of the child were not linked to the school nursing service but the staff supported the schools with additional training. The trust also reviewed schools’ policies and procedures to ensure they were robust.

**Anticipate and plan for potential risks.**

**Universal services for children**
The arrangements for responding to relevant external safety alerts were effective. Staff confirmed the trust sent out emails promptly when there were safety concerns. For example, staff within the school nursing service were made aware of school closures at the earliest opportunity when the trust had been made aware of safety alerts, including bomb threats.

Specialist services for children
However, special school nurses at one school had reported an incident that occurred because the service had not been included in new response plans set out by the school for threats from civil insurgency. The care of a child was put at risk because nurse access was compromised during a ‘lock down’ of the building after a hoax threat. This did not result in harm on that occasion and multi-agency communication was reviewed to prevent it happening in future.

Is the service effective?

Our comprehensive inspection of this trust in 2014 rated the effectiveness of the service as ‘Good’. Since that time the Care Quality Commission has moved the essential standards for transition from child to adult services from the Responsive domain to the Effective domain of the inspection framework. At our inspection of 2014 we rated the trust as ‘requires improvement’ for the Responsive domain. This was in part due to insufficient progress made on transition.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence of its effectiveness. Managers were not always checking to make sure staff followed guidance. The trust had in place systems for holistic assessment of people’s physical and mental health, and social needs. Patients’ care, treatment and support was generally delivered in line with legislation, standards and some but not all evidence-based guidance, including the National Institute of Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes. Outcomes were not always monitored and ante-natal visits were not always done. Care planning for transition was at aspirational and strategy agreement stage and not in place for children.

Universal services for children

The staff within the health visiting service were aware of and were following the latest NICE guidance. For example, staff were following NICE post-natal care (Quality Standard 317), development follow-up of children and young people born pre-term (NICE Guidance 72) and antenatal and postnatal mental health: clinical management and service guidance (Clinical Guidance192). We saw all staff providing care, treatment and advice in line with this guidance.

There was evidence that the service was not delivering the healthy child programme effectively. The healthy child programme focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

As part of the programme the health visiting teams had five key points of contact with children and families which included the antenatal examination (28-34 weeks pregnant); new baby review (10-14 days old); six to eight-week examination; a review of the child before they were one year old; and between two and three years old. We found the health visiting service was not delivering the antenatal visit on a consistent basis to all mothers and were triaging these visits to respond based on risk assessment because of limited staffing capacity. This meant the potential for identifying any safeguarding concerns within the household was compromised. We raised this with the trust and they sent us an action plan for addressing this.
As part of the healthy children programme, the health visiting services were using ages and stages questionnaires (ASQs) to measure and monitor children’s outcomes. The ASQs were also used as an assessment tool to identify a child’s development in relation to communication, gross motor skills, fine motor skills, problem solving, and personal-social skills. We saw the ASQs being used during development reviews. Staff told us and we saw that referrals were made if concerns with a child’s development were identified.

However, outcomes were not being collected, monitored or reviewed so the trust could not be assured that the system was working effectively.

The service had achieved level two accreditation under the UNICEF baby friendly initiative. The baby friendly initiative is a staged accreditation programme. It trains health professionals in hospitals, health visiting services and children’s centres to support mothers to breastfeed. It aims to help all parents to build a close and loving relationship with their baby irrespective of feeding method.

It was unclear if there were effective systems for disseminating the latest evidence based guidance. There was a clinical lead for health visiting within the trust but we were told conflicting information as to whether new guidance or the latest evidence based practice was shared with the health visiting staff globally. Some staff said they received new guidance through email and others said they did not. There was a health visitor forum which took place every six months which staff said had been used to disseminate updates in clinical practice.

We reviewed minutes from operational manager, team leader and team meetings but saw only one reference to discussions regarding updated clinical practice or evidence based care and treatment out of six health visitor team meetings. There were references to updated policies procedures, guidelines and standard operating procedures in two out of three operational managers’ meetings minutes but it did not appear to be a standing agenda item. There were also references to updates in clinical practice in three out of three team leader meeting minutes but this was not a standing agenda item.

Within the school nursing service, nurses told us there were clinical pathways, implemented by the trust, which applied across all schools. For example, there were clinical pathways for sexual health and healthy weight, asthma and diabetes. School Nurse Ambassadors (school pupils who promote the service in their school) we spoke with confirmed this.

**Specialist care services for children**

The trust ran clinics based on the clinical presentation, which allowed for a more targeted evidence-based approach to delivering care. Within Child Development Centres (CDC), the trust provided three specific clinics which were SCAIP (social communication assessment and intervention pathway), GDAIP (global developmental assessment and intervention pathway) and EDAIP (early development assessment and intervention pathway). All three pathways focussed on differing developmental concerns. All three pathways used the same basic admission criteria, which was: children must have significant concerns in two or more areas of development; children must be aged under five years old and must be registered with a Birmingham city GP.

The trust provided us with the assessments undertaken on children referred to the service. The assessments were detailed and accompanied by guidance from the trust. The assessment included an assessment in the home environment. We asked the trust for the evidence base behind the assessment tools; however, they did not provide this evidence.

Nursing staff undertook strength and difficulty questionnaires (SDQ) on four to 16-year olds under the children in care team (CiC). The SDQ is evidence based emotional and behavioural screening questionnaire used in children and young people.

The CiC team used Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) in all patients aged 14 and above within the CiC service. The WEMWBS is evidence based tool used to monitor the mental wellbeing of people.
Staff within the complex care team (CCT) undertook competencies based on the requirements of the child. Registered nurses undertook risk assessments as part of the child or young person’s package. The competencies and assessments were in line with current guidance and best practice.

We saw children with long-term conditions or complex needs that used the specialist services had prescriptive plans for day to day care and support that were in line with up to date good practice and guidelines. However, we saw no personalised goals set out in these plans.

Each child using the short break service had a comprehensive health assessment on file signed off by a registered nurse. Their health care plans were agreed on admission in collaboration with their social care managers. Nurses told us they up updated health care plans as necessary by ‘phoning home’ and discussing any developments with parents/carers before each stay. We saw records of these discussions.

The health care files of six children had care plans which varied in their format and quality. Some were generic plans for example for eating and drinking and pain relief. Other plans were more personalised and in some cases the detail of the plan was within the risk assessment that supported it. For example, the risk assessment for bed and sleeping included details of the therapeutic use of any postural aid sleep system for a child, but there was no night time care plan for the child.

We saw no ‘All About Me’ passports for children on file at the short break service. We asked staff about these and they told us there was practical difficulty getting such documents to stay with the child. Nurses also confirmed the recent internal quality review had highlighted the need to better reflect the voice of the child in health care planning. We did see an ‘All About Me’ sheet of information on file for each child and this included a colour photo of the child.

**Auditing and Benchmarking**

There was not always a clear approach to monitoring, auditing and benchmarking the quality of all services or the outcomes for people receiving care and treatment within the children and families division. At our inspection of 2014 we said the trust should improve the involvement of staff in audit of their service.

**Universal Services for Children**

The trust participated in relevant quality improvement initiatives, such as local and national clinical audits within some but not all services.

Within the school nursing service, audits were carried out to assess whether the clinical pathways in operation within schools were being followed correctly and leading to good outcomes for patients. However, within the health visiting service the only audit being carried out was for patient records.

The health visiting service participated in the annual patient records audit. These were discussed within operation manager meetings. The audit identified some positive and negative practice. For example, areas of improvement included but was not limited to; evidencing that work delegated had been taken in accordance with a plan, evidencing the role of a child’s father, recording all heights and weights, evidencing information had been shared with a GP and information sharing with school nursing and other health services. We did not see any discussion regarding this audit within any of the six health visiting team meetings minutes.

It was not clear from the evidence provided by the service if the health visiting service was meeting their key performance indicators. The healthy child programme stipulated various targets for the health visiting service to meet. For example; a new baby review should take place within 14 days of birth, to assess maternal mental health and discuss issues such as infant feeding. For each key contact the health visiting service had a set percentage target they would have to
achieve.

We were provided with data relating to the percentage of women who received an antenatal visit, but the trust acknowledged it was inaccurate and unreliable due to its reporting system and external issues.

However, data was provided which showed that between April and December 2017:

- 90% of children/parents received a new birth visit within 14 days of birth;
- 93% of children received their six to eight-week review;
- 77% of children received their 12-month development review (children who turned 12 months in the quarter, who received a 12-month review by the age of 12 months) which was below the trust target of 85%;
- 81% children received their 12-month developmental review (children who turned 15 months in the quarter, who received a 12-month review by the age of 15 months) which was below the trust target of 85%;
- 65% of children received their two-year review (children who turned 2-2.5 years in the quarter, who received a 2-2.5 year’s review by the age of 2-2.5 years). This was below the trust target of 85% and below the national average of 75% reported for 2016 and the modal region average reported in 2017 by public health England of between 85% and 90%.

Team leaders within health visiting teams were unsure on whether their team was meeting their KPIs for each contact and told us they did not receive reports on performance for each key contact so there was no local oversight of performance.

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 adjusted for patients’ religious, cultural and other preferences.

During our inspection visit we saw special school nurses were trained to provide enteral feeding to children. This is the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach, duodenum or jejunum.

At the short break service there was a kitchen and chef on the premises to cook and prepare meals, including individual meals for children according to their needs and preferences and family’s values.

Patient outcomes

The service did not always monitor the effectiveness of care and treatment and use the findings to improve them.

At our last inspection in 2014 we said the trust should engage staff in understanding the available performance information, and where necessary develop appropriate outcomes measures and audit programmes. We found at this 2018 inspection that while some progress had been made it was not at a pace that could show significant improvement over four years.
Information about the outcomes of people's care and treatment (both physical and mental where appropriate) were not routinely collected or monitored. There was no clear and consistent approach to monitoring, auditing and benchmarking the quality of these services and the outcomes for people receiving care and treatment.

We spoke with staff within the health visiting service and none could provide examples of patient outcomes being collected, monitored or reviewed. We reviewed four coordinated care pathway guidance documents, all of which included an outcome measure tool which should be completed at specific points. For example, within the pathway for special education needs and disabilities, an outcome measure tool was to be used to ask parents/children what advice had been asked for; did the advice support/help to feel more able to cope/manage the problem; did the advice lead to an improvement in the child's behaviour/sleep/feeding/or other problem. However, we were told by team leaders that this tool was not being used on a consistent basis and none of the team leaders had received any data related to any outcome measures.

**Audits – changes to working practices**

The trust had participated in 14 clinical audits in relation to this core service as part of their Clinical Audit Programme.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Date/ regularity of audit</th>
<th>Key successes</th>
<th>Key areas of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children</td>
<td>Quarterly</td>
<td>There was more communication with parents/carers</td>
<td></td>
</tr>
<tr>
<td>Learning from Serious Case Reviews &amp; DHRs</td>
<td>Quarterly</td>
<td>Raised awareness amongst child practitioners to advocate for children and escalate concerns. Early help training and workshops developed and rolled out to frontline staff.</td>
<td>Improvements required in record keeping standards and care planning.</td>
</tr>
<tr>
<td>Monitoring of Quality of Multi Agency Child Protection referrals (inc Sandwell School Nursing)</td>
<td>Quarterly</td>
<td>Quality of referrals identify and articulate concerns appropriately</td>
<td>None at present</td>
</tr>
<tr>
<td>Section 11 Audit</td>
<td>Bi-annually</td>
<td>Maintenance of compliance</td>
<td>None at present</td>
</tr>
<tr>
<td>Customer Satisfaction Audit</td>
<td>Bi-annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment Audit Clinical areas (IPS tool)</td>
<td>Quarterly</td>
<td></td>
<td>Furnishings composed of permeable material, lack of storage, decontamination of equipment, lack of clinical hand wash basins.</td>
</tr>
<tr>
<td>Clinical Records Audit (DIP Sample) (Corporate)</td>
<td>Q4 audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit of 100 CIC Health Assessments</td>
<td>April 2017</td>
<td>Great improvements in quality of paperwork. The results have shown that the 12 aims from 2016 audit have</td>
<td>No concerns identified.</td>
</tr>
<tr>
<td>Event</td>
<td>Date</td>
<td>Details</td>
<td></td>
</tr>
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<td>-------</td>
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</tr>
<tr>
<td>Leavers Letters Audit for the CIC Service</td>
<td>April 2017</td>
<td>All nurses within the team completed leaver’s letters 1st April 2016 and 31st March 2017</td>
<td></td>
</tr>
<tr>
<td>Audit of 30 Health Assessment Forms completed by Sandwell School Nurses</td>
<td>April 2017</td>
<td>The results for 2017 are very positive and the results can be seen clearly this year.</td>
<td></td>
</tr>
<tr>
<td>Audit of 30 Health Assessment Forms completed by Staffordshire School Nurses</td>
<td>April 2017</td>
<td>The 2017 results show a great improvement. The nurses in Staffordshire were not used to typing the reports and have worked hard to ensure everyone does this.</td>
<td></td>
</tr>
<tr>
<td>A service evaluation of the mechanisms in place for medicine management in Staffordshire special schools where shared responsibility is in place. (Service Evaluation)</td>
<td>March 2017</td>
<td>Special Schools and School Nurses have good system in place for Medication Management.</td>
<td></td>
</tr>
<tr>
<td>A service evaluation to determine which health related policies schools in Staffordshire have in place in order to determine the support required from the School Nursing Service and the training requirements of school nurses to be able to offer this support.</td>
<td>October 2017</td>
<td>At the conclusion of the audit there were two incidents of children dying as a result of a serious medical condition, one of which occurred in Birmingham. This brought into sharp focus the role of the school nurse in providing training for teaching staff.</td>
<td></td>
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</tbody>
</table>
| Audit of C&F division health advice for Education Health and Care Plans | September 2017 | The audit process highlighted some key areas for development in:  
  - ensuring EHC health advice is captured and readily accessible in clinical records  
  - process for provision of advice following requests from BCC  
  - process for ensuring parents can refuse |
| | | 1. Not a consistent method in place for storing submitted advice or for recording & coding when it was requested and sent.  
  2. Some services (e.g. Health Visiting and Community Nursing) held relevant information which could contribute to EHC |
permission for advice to be shared with BCC
• ensuring that health advice is accurately represented in the EHCP
• amending the design of future audits to enable greater clarity in relation to compliance with relevant standards
assessments but were not routinely asked to provide advice.

Specialist services for children

The number of children and young people in care (CiC) that had received the required health checks between April 2017 and March 2018 were:

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
<th>Percentage achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cohort of patients</td>
<td>1,394</td>
<td></td>
</tr>
<tr>
<td>Total with sufficient medical checks</td>
<td>1,297</td>
<td>93.04%</td>
</tr>
<tr>
<td>Total with sufficient dental checks</td>
<td>1,314</td>
<td>94.26%</td>
</tr>
<tr>
<td>Total health achievements for children in care</td>
<td></td>
<td>93.65%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
<th>Percentage achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total four to 16-year olds with a completed strengths and difficulties questionnaire</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Total zero to five-year olds with sufficient developmental checks</td>
<td></td>
<td>81%</td>
</tr>
<tr>
<td>Total eligible children with a completed Warwick-Edinburgh Mental Wellbeing Score</td>
<td></td>
<td>19%</td>
</tr>
</tbody>
</table>

The CiC team did not provide any information on a target in which they should achieve; however, did report yearly to the local authority.

Universal Services for children

Within the mainstream school nursing service, audits were carried out to assess whether the clinical pathways in operation within schools were being followed correctly and leading to good outcomes for patients.

The mainstream school nursing service participated in the National Child Measurement Programme (NCMP) across schools in Birmingham and Sandwell. The NCMP measures the height and weight of children in reception class and year 6, to assess overweight and obesity levels in children within primary schools. The data can be used to support local public health initiatives and to inform planning and the delivery of services for children.

The mainstream school nursing service was unable to benchmark itself against other local services due to the way they were commissioned. The service they delivered differed from those locally. However, the service did meet with other local services to compare services.

Managers of the special schools nursing service told us they used Essential Care Indicators (ECI) for wound care of a child, for example device related wounds.

Competent staff

Qualifications, skills and experience
The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance and hold supervision meetings with them to provide support and monitor the effectiveness of the service.

Health visitors were registered nurses at Band 6, their team leaders were band 7. Special school nurses were paediatric trained with acute care experience. Children's nurses led the health care input each shift at the short break service. Inclusion services for children were staffed by qualified therapists. Complex care was led by registered nurses and healthcare assistants with NVQ / QCF qualifications at level two or three. The children in the care team consisted of registered nurses.

Clinical Supervision
At our last inspection of the service in 2014 we said the trust should ensure all staff received appropriate supervision. At this inspection we found some improvements but this was inconsistent.

The trust did not collect data regarding clinical supervision activity, therefore we were unable to report on performance. The trust had provided a statement to say a wide range of support for clinical supervision was available in the trust including training, supported action learning, and roadshows. The trust reported they were, at the time of our inspection, working with divisions to create a practical method of capturing clinical supervision activity in order to be able to produce centralised reports.

(Source: Routine Provider Information Request (RPIR) – Clinical Supervision tab)

The trust had arrangements for supporting and managing staff to deliver effective care and treatment but these were not always applied consistently.

Universal Services for children
The arrangements varied for supporting and managing staff to deliver effective care and treatment differed within the health visiting service. Most staff we spoke with confirmed they had monthly one-to-one meetings with their team leaders. However, there were some within the health visiting service who only had one-to-one meetings on an ad hoc basis. This was confirmed by some team leaders.

Clinical supervision did not take place on a consistent basis within the health visiting service. Team leaders and staff told us they did not attend any supervision exclusively for their clinical practice on a consistent basis. We were told that clinical supervision would only usually be carried out if it was restorative.

Learning needs of staff were identified. A health observation tool was used annually to audit clinical staff practice. The audit was used to assess staff on their practice in relation to numerous areas which included but was not limited to:

- Infection prevention and control;
- Equality and diversity;
- Privacy and dignity;
- Safeguarding;
- Observation/assessment;
- Quality of care delivered;
- Quality assurance; and
- Record keeping.

The auditor used the tool to identify areas of improvement and training needs. The observation tool was part of the appraisal process and feedback was provided to staff.
There were 12 clinical practice teachers within the health visiting service. They were responsible for ensuring health visitors and assistant practitioners were delivering care and treatment which was best practice and of high quality. Their role was 80% clinical and 20% practice teaching. Staff told us they used the clinical practice teachers in their teams when additional advice and guidance was needed.

Staff within the school nursing service confirmed they attended clinical supervision meetings every four to six weeks. They said they could raise any issues they had regarding their practice and seek advice on challenging issues.

Specialist services for children

Children attending special school had a named nurse within the team.

To improve the effectiveness of children’s wound care from medical devices; one nurse in the special schools’ team had acquired competence at non-medical prescribing. This meant dressings could be accessed quickly without going through the GP and this improved outcomes for those children. This nurse was being shared through a number of special school nursing teams however. Managers told us they hoped that further nurses would receive the training from September 2018.

The complex care team consisted of registered nurses and support workers. Team leaders told us there was a good retention of nursing and care staff in that service. Support workers were Band 3 level staff. Each support worker underwent a package of competencies for the children and young people they provided care to, for example ventilator, feed pump and catheterisation competencies. Support staff undertook competencies to administer medication. Registered nurses reassessed each support worker on a yearly basis to ensure continued competence, and sooner where new skills were needed or the patient’s needs changed. Experienced support staff supported new support workers until they had achieved competence to ensure the effective safe delivery of care.

We requested information from the trust about seven competencies and the number of support staff that had completed them. The trust told us:

<table>
<thead>
<tr>
<th>Competency</th>
<th>Percent of support staff undertaken initial training</th>
<th>Percent of support staff compliant with 12-month refresher training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilation</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Tracheostomy care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Enteral feeding: nasogastric tube (NGT) feeds</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Enteral feeding: percutaneous endoscopic gastrostomy (PEG) feeds</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Catheterisation</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Seizure management</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>Medication management</td>
<td>100%</td>
<td>92%</td>
</tr>
</tbody>
</table>

The trust told us that three staff required refresher training on PEG feeds; however, one was on long term sick and two had refresher training booked for June 2018. Three staff required 12-month refresher trainer on seizure management; however, one was booked to undertake the training in May 2018 and the second in June 2018. Five support workers needed medicine fresher training; however, two were on long term sick and three had this planned for June 2018.
The short break service had experienced a shortage of qualified nurses to provide the trust’s health contribution and this was being managed through the division’s risk register.

We noted the trust could assure itself of the competencies of local authority care staff working alongside them in the short break service. It provided their training. We spoke with the nurse responsible for maintaining the system of training those workers for each child’s needs and we saw the current dashboard of annual updates. It included asthma awareness, Bilevel Positive Airway Pressure (BiPAP) awareness, epilepsy and BM awareness, pump training, stoma training, tube feed awareness training. How the protocols applied to each named child was on the dashboard.

**Appraisal rates**

From April 2017 to March 2018, 84.7% of all staff within the community services for children families had received an appraisal compared to the trust target of 90%. For nursing staff, this figure was 84%, while medical staff have a completion rate of 54%. The number of medical staff was much lower than the number of non-medical, therefore each medical member of staff accounts for a higher proportion of the total than non-medical staff.

**Community services for children and families - all staff**

<table>
<thead>
<tr>
<th>Staff Role</th>
<th>Number completed</th>
<th>Number of individuals required</th>
<th>% Complete</th>
<th>% Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>104</td>
<td>111</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>197</td>
<td>226</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>HCA</td>
<td>246</td>
<td>288</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>454</td>
<td>542</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>21</td>
<td>39</td>
<td>54%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P43 Appraisals tab)

Data we requested from the trust after our inspection visit showed the trust did not meet its target of 90% last year for the children’s complex care team. The rate for health care assistants (HCA) was 78% and for nurses was 80%.

**Revalidation**

The service monitored the renewal and re-validation of nursing qualifications.

**Universal services for children**

Within the health visiting service there was a revalidation section within nurse’s annual appraisal and appropriate reminders were given to staff of upcoming dates. Staff said they had no problems accessing and obtaining training to develop their practice. They said they were supported by their supervisors when revalidating.

**Specialist services for children**

Nurses we spoke with at the short break service confirmed they had undertaken their re validation.

**Multidisciplinary working and coordinated care pathways**
Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare including alongside social care professionals, supported each other to provide good care.

Care was delivered and reviewed in a coordinated way when different teams and services were involved. During our inspection of 2014 we said the trust should make better progress on transition planning. We saw strategic plans set out in consultation with other agencies and stakeholders regionally with a view to implement in 2018/19. However, at the time of this 2018 inspection there was not a specific transition to adult services plan in place on record for each child with additional needs.

Universal Services for children
The health visiting team worked closely with colleagues from other services within the trust when interventions from specialist services were required. Staff within the health visiting team told us their relationships with specialist services, including but not limited to physiotherapy, occupational therapy teams and speech and language therapy, were effective and information between them was shared promptly.

The health visiting teams had close links to GP practices and midwives, with each health visitor having assigned practices. Health visitors held monthly liaison meetings with both midwives and GP practices to maintain their relationships, share information and raise any concerns. Staff felt that having regular contact assisted with communication and cooperation. Quarterly safeguarding meetings with GP practices also took place to ensure both parties were aware of all children under child protection plans.

There were coordinated care pathways within the health visiting service but they were not all up to date. We saw evidence of care pathways for behaviour management concerns, new born heel prick test, special education needs and premature babies. Each pathway highlighted the responsibilities of health visitors and other services within and outside of the trust, including what steps needed to be taken to involve them. However, two of the pathways in use were out of date, these included behaviour management concerns and new born heel prick test. These pathways should have been reviewed in October 2015 and April 2016 respectively.

The mainstream school nursing service worked with the all secondary schools/community schools across Birmingham and Sandwell to provide a confidential nurse drop in services for pupils. Primary schools are offered the opportunity to run parent drop in. The school nurse ambassador project (SNAP) meant schools nurses worked with an identified member of school staff to act as key contact for the project. School nurses also worked together with schools to support the identification of young carers within communities and assist in meeting their needs.

Specialist services for children
Special school nursing teams were working on transition pathways for children and young people. For example, at Victoria School, nurse managers told us they held transition clinics during May and June each year for professionals involved in the life of each child. This was in order to ensure a smooth pathway to the college, or to complex care services or home. These clinics aimed to identify which services a child would need as they moved on. They had paediatrics consultant and registrar input and leaflets were sent to a child’s home. Divisional leaders had an ongoing relationship with college representatives for transition.

Staff in the complex care team could not direct us to any transition plans in children’s health care files. The informal processes were not robust in ensuring plans were communicated and documented.

Nurses in the short break service told us transition planning was ‘on the table’ and we saw no reference of it in the eight children’s health care files we looked at. The service faced challenges with supporting young people to make the transition to adult services. The manager told us the
contractual arrangements were such that parents of children were entitled to access 49 nights each year but adult offspring got fewer than this.

The trust sent us document that detailed strategic delivery plans to prepare young people with additional needs for adults’ life. These were multi agency and multi professional, in approach and in line with nationally agreed aims and the principles of good practice, set out in the CQC report of 2016 ‘From the Pond into the Sea: Children’s Transition to Adult Health Services’.

The strategy was to be delivered between 2018-2021 with pilot cohorts of children age 14 to 18 and 18 to 21 years during the first year. We noted some documents were yet to be ratified by the trust board.

We did not see individual transition plans for children at any services when we asked for them or in any children’s file we looked at during our inspection visits.

We asked divisional leaders about this, they assured us plans were in existence for children but held in different sets of records, across the multiple of professionals involved with their health care. However, we did not see these at inspection nor were any offered to us when we asked. Leaders assured us they were looking to the roll of out electronic patients records to specialist services for children in the division to achieve these plans. This roll out was not due until autumn 2018.

**Health promotion**

**Children and those close to them, who used services, were empowered and supported to manage their own health, care and wellbeing and to maximise their independence.**

**Universal Services for children**

Parents using the health visiting services were encouraged to be as independent as possible. For example, the trust supported national priorities to improve the population’s health. Across the health visiting service, parents were being given advice and support in respect of smoking cessation, diet and physical activity, breastfeeding and healthy weaning, prevention of sudden infant death and maintaining infant health. We observed staff advising parents on the dangers of smoking and signposting them to organisations who could offer them additional support. We saw mother’s being encouraged to breast feed and advised on all the benefits, but were not pressured.

The school nurses service across Birmingham and Sandwell offered health education across primary schools, parent drop in’s and ambassador groups. We spoke with some of the Birmingham school nurse ambassadors. They confirmed their great interest in learning about and passing on health education within their schools through the school nurse service.

**Specialist services for children**

The children in care team had developed a health passport for young people that encouraged them to keep a record of their healthcare, for example when immunisations happened and when they last visited a dentist. The health passport allowed the young person to take ownership of their healthcare and encourages them to engage and improve their overall health and welfare. The CiC team provided sexual health advice. A paediatrician gave us an example of giving contraception and advice to a 17-year-old who had come for a yearly review.

**Information to enable effective care delivery**

**Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment.** Not all groups of staff had access to an electronic records system that they could all update.

The trust had the contract to run the Child Health information service (CHIS) within the West Midlands, South Warwickshire and Staffordshire and Shropshire. Birmingham Community
Healthcare NHS Foundation Trust health visitor services received their allocation for visits to provide the universal health care in their patch through the CHIS. CHIS managers told us their system aimed to predict and then record an outcome for every universal intervention for a child. It also sent chase letters to health visiting teams. Clinicians had access to the CHIS records using a smart card.

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. The school nursing teams and health visitor teams worked together when a child started primary school. At the point the child started primary school the health visitor would contact the relevant school nurse to make them aware of any issues and identify if any referrals to any other services were required.

Special school senior nurses confirmed all the nurses had access to the electronic care records system.

Complex care support staff confirmed they used paper records and did not have access to the electronic system. They talked about the trust’s future plans to roll out smart phones for their use to records essential interventions with their children, for example the administration of lunch time medication at school. This was expected to begin in autumn 2018.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

*Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.* They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care but did not always make records of this.

The results from the 2017/18 trust records audit for children and families’ division; ‘In the last 5 entries if treatment was provided do the notes record whether the patient or their designated representative gave valid informed consent to treatment or declined treatment?’ scored only 52% which was lower than the previous year.

‘Where the last five entries indicate staff were communicating with someone other than the patient does the record indicate the name of the person staff were talking to and their relationship to the patient?’ scored 18.8% compliance.

**Specialist services for children**

We asked staff in child development centres (CDC) about their responsibilities to gain consent before undertaking any interventions. Staff knew to ask the child or young person where appropriate, or the person with parental responsibility. Staff were aware of the need to involve social workers where social care had parental responsibility for a child or young person.

Nurses we spoke with at the short break service told us they worked within obtaining parental consent for children in their care. Staff also described how they learned to understand each child’s facial expressions and body language to obtain consent for day to day preferences and interventions such as food and drink, clothes and activities. They said Makaton (a language programme using signs and symbols to help people to communicate) was taught to the children in the local special schools and staff had been trained to use it with children who had no verbal communication.

**Mental Capacity Act and Deprivation of Liberty Safeguards training**

(Appplies young people over 16 years)

The trust set a target of 85% for completion Mental Capacity Act (MCA) training. A breakdown of compliance for mandatory courses from April 2017 to March 2018 for medical/dental and nursing staff within community services for children is below.

**Medical and dental staff**
<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff last year</th>
<th>% Completion</th>
<th>Trust Target (%)</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA/DOLs</td>
<td>29</td>
<td>39</td>
<td>74.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff within the children and families service did not meet the completion target for the MCA training course.

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff last year</th>
<th>% Completion</th>
<th>Trust Target (%)</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA/DOLs</td>
<td>503</td>
<td>542</td>
<td>92.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff within the children and families service met the completion target for MCA training.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

**Deprivation of Liberty Safeguards**

Birmingham Community Healthcare NHS Foundation Trust told us that trust wide, 83 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority from January 2017 to December 2017. However, none of these were pertinent to community health services for children and families community services.

*(Source: Routine Provider Information Request (RPIR) – P13 DOLS tab)*
Is the service caring?

At our last inspection of 2014 we rated these services as ‘Good’. At this inspection we maintain the rating as ‘Good’

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Universal Services for children

Staff within the health visiting service took the time to interact with children and those close to them in a respectful and considerate manner. We observed many conversations between parents and staff which were often instigated by staff. On each occasion, staff addressed children and those close to them by their preferred names and showed interest in what was being discussed. They introduced themselves by name and told them what their role was. We observed all staff speaking to children in an age appropriate way.

Parents were encouraged and supported by staff. We saw health visiting staff encouraging parents to persist with weaning and routines which would improve their child’s health. For example, we observed staff taking their time to explain in detail what steps they should take to encourage their child to eat and improve their sleep pattern.

The privacy and dignity of children and their family was respected and promoted. For example, the health visiting teams had access to additional rooms, within the bases where they held clinics, which could be used if parents wanted care or conversations to take place in private.

Parents told us they were happy with the care and treatment their children received. We spoke with two parents using the health visiting service and both were complimentary about the treatment their children had received. Both parents said staff were kind and had treated their children well.

Specialist services for children

We observed a group session at Park House child development centre (CDC), where four families attended. We observed staff welcoming families in a kind and friendly manner. We observed staff interactions with parents and children and found all interactions conveyed compassion and kindness.

We observed two consultant consultations at Allens Croft CDC. The consultants were approachable, kind and compassionate in how they spoke with families and patients.

The Children in Care (CiC) team collected feedback from children, young people and families that used the service. We reviewed feedback from April 2017 to May 2018 and found that all the feedback was positive. The feedback questionnaire asked how likely the patient would be to recommend the service. Of the 62 pieces of feedback, 54 people answered the question. Of the 54 responses, one answered “don’t know”, five answered “likely” and 48 answered “extremely likely”.

The feedback questionnaire asked, ‘overall how would you rate the service you have received?’. Of the 62 pieces of feedback, 56 provided a response. Of the 56, one answered “good”, three answered “very good” and 38 answered “excellent”.

The respondents provided additional comments, which included:

- Very friendly and made the foster children and myself comfortable
- All the nurses are really nice
- As a carer I know it’s important to be listened to and I was when I was here
- Very friendly and very child friendly approach
The Paediatric Sexual Assault Service (PSAS) collected feedback from children, young people and their families where appropriate. Some of the feedback received between September 2017 and March 2018 was:

- You are all very kind and supportive
- An amazing service. Thank you for reassuring me
- Thank you for being so helpful and friendly
- Fantastic, you were all so good with my daughter

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.** Staff understood the impact a child could have on a parent’s wellbeing

**Universal Services for children**

Staff within the health visiting service could recognise if a child was affecting a parent’s wellbeing and discussed this with them at clinics and visits. We observed staff asking parents how they were emotionally and offered them the opportunity to talk about it in detail. For example, we saw a health visitor comforting a parent whose child was not eating much and only drinking formula. The health visitor reassured the parent by going into detail about how much the child was drinking and eating and explaining that the parent was doing everything they should be.

We observed school nurses and divisional leaders treating young people in the school nurse ambassador scheme with respectful affection and regard for their individual personal achievements within the scheme.

**Specialist services for children**

The Complex Care Team (CCT) told us that nursing staff and support workers would provide support to families as required during home visits. We saw families utilising the on-call nurse system for advice and guidance in times of crisis.

The Paediatric Sexual Assault Service (PSAS) set out to ensure at every examination or consultation a crisis worker was available for children and young people to talk to and provide support. Also, that counselling was offered to all children and young people that attended PSAS.

The Children in Care (CiC) team told us they had access to other organisations that could provide targeted support to children and young people. The CiC team gave specific examples of support for transgender young people and those with a mental health condition.

Special school nursing managers told us the teams gave a lot of emotional support to families. Some children were in school for many years and because they had life limiting conditions, sadly died. We saw some letters and cards from families and parents thanking the staff for the support they had been given in such difficult times. Managers told us staff were also given support at such times.

We observed special school nurses, support workers and therapists treating children with respect and affection, giving them appropriate physical contact and positive responses to their communication needs.

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

**Staff routinely involved people who used services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment.**
Universal Services for children

Staff in the health visiting service described how they recognised when parents needed additional support to help them understand and be involved in their child’s care and treatment. Staff enabled parents to access this. Staff told us they would endeavour to source any additional support patients required.

Parents could access further information and ask questions about their child’s care and treatment. Staff were available to answer any questions about the care being provided and responses were open and honest. Parents told us that if they had any questions they could discuss them with staff. Parents were aware of why checks and reviews were being carried out. For example, in the health visiting service, we observed a clinic where an “Ages and Stages Questionnaire” was being reviewed. The parent was shown the score their child had been assessed as achieving and they were asked if they wanted to know more about what it meant. They were told that the score achieved meant their child was within expected targets and no referrals to specialist services would need to be made.

The mainstream school nursing service provided a health questionnaire to year seven pupils when first starting secondary school. Pupils were encouraged to outline their strengths and difficulties on the questionnaire. School nurses told us they then discussed these with the pupils to ascertain which the most important issues were. Staff said this tool enabled them to capture the voice of the child and address the concerns that were most important to them.

Specialist services for children

The Children in Care (CiC) team had developed a health passport for children in care. This contained information about their medical history and encouraged young people to track their own health and welfare needs.

The Paediatric Sexual Assault Service (PSAS) aimed to give children and young people the choice over a male or female doctor to examine them. This gave control back the child or young person in a difficult and stressful environment, and allowed the child or young person to have a say in how the examination would progress.

The Complex Care Team (CCT) told us they involved families (and where possible children and young people) in discussions about care. However, we did not find evidence of partnership working between families and patients and staff. For example, families and or young people did not countersign care plans to acknowledge and agree to the plans that staff had put in place.
Is the service responsive?

At our last comprehensive Inspection of the trust in 2014 we rated the responsiveness of services to children and families as ‘requires improvement’. These shortfalls related to specialist services for children.

Transition services are now inspected under the domain of ‘effective’ and our findings for the 2018 inspection appear above in that part of this report.

During this 2018 inspection we found insufficient progress had been made on referral time to treatment. We additionally found the health visiting service was not meeting some national key performance indicators. We have maintained this rating as ‘Requires Improvement’.

Planning and delivering services which meet people’s needs

The trust planned and provided services in a way that met the needs of local people.

As part of the health visiting service’s restructure, which was being undertaken at the time of our inspection, the health visiting teams were being redesigned to align teams to council districts instead of GP practices.

This involved planning the service to work closely with four children’s charities across Birmingham. The health visiting service and all four charities were already working in partnership aiming to ensure safe and high-quality care, for example; referrals could be made to charities to access parenting classes and support for mothers with post-natal depression. The health visiting service and charities were also running a pilot for weekly integrated meetings which were being used to share information and coordinate processes.

Mixed sex breaches

Mixed Sex Breaches were defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definition. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages, and therefore includes children’s and adolescent units. This means that boys and girls should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be in the event of a family admission on a children’s unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

The trust reported no mixed sex breaches during the reporting period of January 2017 to January 2018 for children and family’s community services.

(Source: Routine Provider Information Request (RPIR) P55 Mixed sex)

The short break service was the only overnight accommodation provided within the children and families division. The service was provided for girls and boys. We saw that each room contained only one bed and was set up to meet the needs of the child expected to be admitted after school on that day. Bathroom facilities were identified for girls, or for boys.

Universal services for children

The trust held the contract to provide a universal service called the Child Health Information service (CHIS) for the region (Birmingham, Coventry, Dudley, Herefordshire, Sandwell, Shropshire, Solihull, Staffordshire, Stoke-on-Trent, Telford and Wrekin, Walsall, Warwickshire, Wolverhampton and Worcestershire). This operated as a Fail-Safe service.

CHIS managers described their role as supporting clinical services by making them aware of every child. They also prompted and chased up clinical services to make their relevant contacts.
with the child. These included for example, the blood spot screening test, ante natal clinic appointments and letters to parents if there was a child on the system without a school place at benchmark ages. The manager told us the CHIS processed births each Monday and must notify these births to health visitors on the day they are received. The health visitor then had 10 to 14 days in which to make the contact with the child. Overall the CHIS scheduled 5,000 health visitor appointments each week.

The CHIS system provided an outcome for each intervention for every child in the patch. Clinicians could access these records and school nurses could view them. Some records, could be only part viewed for example, for audiology.

The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care.

Arrangements were in place to access translation and interpreting services. The trust had a translation and interpretation policy. There were translation and interpretation services available to staff within community services for children and families. Information on the trust website for children and families’ services was available in a wide range of languages.

Staff within the health visiting service were aware of how to access the service and provided us with examples of when they had used it. We also observed patient care being delivered to a patient whose first language was not English and an interpreter had been arranged.

The school nursing service worked with schools at the beginning of each year to review their needs and deliver a service tailored to them. This meant the services delivered in schools differed as the same level of service was not always required. A further three meetings took place throughout the year to ensure the service was still being delivered in line with the needs of the pupils. If it became apparent that the needs changed the service delivery was altered as necessary.

Specialist services for children
We asked two members of staff at child development centres (CDC) about equality, diversity and human rights (EDHR). They told us they had not received any EDHR training. We found information leaflets were not provided in a format other than written English. This meant information was not accessible for those services users and carers with a visual impairment or where English is not their first language. However, we found that staff knew how to access translators and gave examples of when both spoken and British Sign Language (BSL) interpreters were used.

The reports written by staff following the assessment of a child or young person were only available in written English. Therefore, carers whose first language is not English or those with a visual impairment were unable to read the report detailing the outcome from the assessment. The report contained recommendations for interventions before the first targeted appointment that carers would need to follow.

Neither of the two CDCs we visited had specific areas for mothers in which to breast feed their infants should they wish for privacy.

The Children in Care (CiC) team provided good examples of EDHR knowledge and how to signpost children and young people towards additional services and groups. For example, the CiC team explained how they could access a transsexual support group for young transgender people, a mental health support group and a youth group for vulnerable young people ran by a Birmingham children’s charity.

The Paediatric Sexual Assault Service (PSAS) staff had no specific training on how to support groups of children and young people with additional requirements, for example transgender young people. Staff we asked were unaware where they would access specific support for these
groups of children and young people.

We found the weighing room at Park House CDC had three narrow steps to access it. The ‘sit on’ scales for older children, which could be used for those children and young people with and without a physical disability, were fixed in place. Therefore, the scales were inaccessible to those service users who were unable to walk up the steps or those carers unable to lift a child into the weighing room. Staff were unable to provide an alternative access arrangement and told us usually only children and young people that come for an autism assessment would be weighed.

**Meeting the needs of people in vulnerable circumstances**

**The service took account of patients’ individual needs.**

**Specialist services for children**

The trust runs a regional paediatric sexual assault service (PSAS). PSAS provided a service for anyone under the age of 18 who reported a sexual assault, including historic sexual assaults. The service was staffed by a nurse and consultant paediatrician 24 hours a day, all year round. The PSAS aimed to assemble a nurse, paediatrician, crisis support worker, social worker and police (where required) at the PSAS suite within 90 minutes of a referral being made.

The PSAS team told us they meet this target in the vast majority of cases, and where this is not met is usual due to the circumstances surrounding the child or young person. The PSAS team gave an example of an under five-year-old being referred to the service late at night, but it was decided to allow the child to rest and come to the centre early the next day to be cared for.

The short break service offered children with complex needs a stay for a few days every seven weeks.

**Access to the right care at the right time**

**People could not always access the service when they needed it.** Waiting times from treatment and arrangements to admit, treat and discharge patients were not always in line with good practice. Patients did not always have timely access to initial assessment and follow up therapist services.

**Universal services for children**

The trust provided data on their key performance indicators for the health visiting service. The service was commissioned to carry out five key contacts for each child referred to them. This included an antenatal examination (between 28 and 34 weeks of a mother’s pregnancy); new baby review (between 10-14 days old); six to eight-week examination; a review of the child before they are one year old; and between two and three years old. The trust gave us data which showed that between April and December 2017:

- 90% of children/parents received a new birth visit within 14 days of birth;
- 93% of children received their six to eight-week review;
- 77% of children received their 12-month development review (children who turned 12 months in the quarter, who received a 12-month review by the age of 12 months);
- 81% children received their 12-month developmental review (children who turned 15 months in the quarter, who received a 12-month review by the age of 15 months);
- 65% of children received their two-year review (children who turned 2-2.5 years in the quarter, who received a 2-2.5 year’s review by the age of 2-2.5 years).

The trust did not provide data relating to the percentage of women who received an antenatal visit between April and December 2017. We were provided with data which showed 96% of women had received an antenatal visit between January and March 2018, however, the trust told us there were known gaps in the data due to lack of notifications from midwifery teams. The trust was
working with midwives to improve this. The trust confirmed the percentage was likely to be overstated. We therefore do not know how the service was performing in respect of all five key contacts.

Multiple team leaders and staff across all the health visiting teams we spoke with told us antenatal visits were not always being carried out. This was for several reasons which included delayed notification and limited capacity within the health visiting service. Local leaders told us they were therefore prioritising contacts. For example, they prioritised antenatal visits where cause for concerns had been raised by midwives and/or GPs or the referral was for a first-time mother. This meant that referrals relating to mothers who had already had children were rarely being carried out unless there was a cause for concern.

We found this prioritisation process differed across health visiting teams as there was no formalised practice in place. When referrals for antenatal visits were received, the teams allocated them to those with capacity but when no one had capacity teams were dealing with them in different ways. For example, some teams were calling the women to notify them they could not offer an antenatal visit, but discussed any queries or concerns they may have and offered a visit if needed. Other teams were not contacting the women when the antenatal visit could not be allocated and there was no further contact with the women until after their child was born. In each case the health visiting teams were recording the date the referral was received, name, address, date of birth of the women and estimated due date. We have raised this with the trust and they have assured us they are acting quickly to address it.

However, the health visitors were not notifying other agencies of the unallocated referrals. Local leaders told us data on the number of unallocated referrals had been collected and collated in the past but at the time of our inspection this practice had ceased. There was no data available on the number of referrals which had not been allocated or the reasons why the visits were not carried out. The lack of consistent management and oversight was of significant concern. This meant the trust could not assure itself risk was being well managed. We have asked the trust to respond to this situation.

Health visitors were expected to make four contacts with children/families per day. This included both home and clinic contacts. We reviewed data which confirm the health visiting service was meeting this key performance indicator between May 2017 and April 2018.

The trust had an electronic central booking system for community paediatrics appointments and new ‘inclusion’ services appointments. These were speech and language therapy (SALT), occupational therapy and physiotherapy. The manager told us they were trying to reduce a follow up appointment waiting list. These were triaged to make sure the follow up was not lost and extra clinics had been provided to ‘mop up’ this list. For example, the trust had recently received a bulk referral list for Attention Deficit and Hyperactivity Disorder (ADHD) service appointments, a locum was engaged and paediatric consultants also provided two Saturday clinics.

Referrals came from schools, health services, GPs and acute services. A new referral went on the system within 24 hours and a community consultant paediatrician aimed to triage these within one week. The system report indicated breaches of referral time. As these paediatricians were based in child development centres around the city they could interact within a multi-disciplinary team for ADHD, adoption, neurological development and fostering.

However, managers told us the referrals were showing an increase of 10% each year lately and the booking service would not hit targets as there were insufficient ‘slots’ available to appoint to. One hundred and fifty ‘slots’ were currently needed each month to meet demand. Staff told us they were highly engaged and worked together to contribute to ideas about new follow up pathways to reduce the back log. However, some were not optimistic this could be achieved.

Accessibility
The largest ethnic group within the trust catchment area was White: English / Welsh / Scottish / Northern Irish / British with 53.1% of the population.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First largest</strong></td>
<td></td>
</tr>
<tr>
<td>White: English/Welsh/Scottish/Northern Irish/British</td>
<td>53.1%</td>
</tr>
<tr>
<td><strong>Second largest</strong></td>
<td></td>
</tr>
<tr>
<td>Asian/Asian British: Indian or British Indian</td>
<td>6.0%</td>
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<tr>
<td><strong>Third largest</strong></td>
<td></td>
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<tr>
<td>Black/African/Caribbean/Black British: Caribbean</td>
<td>4.4%</td>
</tr>
<tr>
<td><strong>Fourth largest</strong></td>
<td></td>
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<tr>
<td>Asian/Asian British: Bangladeshi, British Bangladeshi</td>
<td>3.0%</td>
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(Source: Routine Provider Information Request (RPIR) – Accessibility tab)

**Referrals**

The trust had identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

Birmingham Community Healthcare NHS Foundation Trust does not have analysis of referral to treatment and onset of treatment. They also do not have internal targets for referrals to treatment, but do adhere to the national referral to treatment target for consultant-led compliant services of 18 weeks.

The table below shows the number of days from referral to face to face contact.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of in-patient ward or unit</th>
<th>Days from referral to face-to-face contact – Actual (median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community (multiple sites)</td>
<td>Child Development Centre</td>
<td>153</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Child Speech And Language Therapy</td>
<td>145.5</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Children In Care</td>
<td>47</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Children Occupational Therapy</td>
<td>212</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Community Children's Nursing &amp; Palliative Care Service</td>
<td>29</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Health Visiting</td>
<td>133</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Paediatric A</td>
<td>105</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Paediatric Eye Service</td>
<td>60</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Paediatric Physiotherapist</td>
<td>105.5</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Paediatric Short break Training Service</td>
<td>2</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Paediatrics</td>
<td>126</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Paediatrics Dietetics</td>
<td>46</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>School Nursing</td>
<td>96</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Special School Nursing</td>
<td>79.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Referrals tab)
Specialist services for children
This meant for example, the trust was not meeting the required target of 92% for referral to treatment times (RTT) for all the services provided within CDCs. On average, CDC clinics saw 36% of referrals within 18 weeks between October 2017 and March 2018.

The number of children seen within the 18 weeks RTT target month on month were as follows:

<table>
<thead>
<tr>
<th>Month and Year</th>
<th>Percentage of children seen within 18 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>April to June 2017 (average)</td>
<td>42%</td>
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<tr>
<td>July to September 2017 (average)</td>
<td>43%</td>
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<tr>
<td>October 2017</td>
<td>37%</td>
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<tr>
<td>November 2017</td>
<td>37%</td>
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<tr>
<td>December 2017</td>
<td>34%</td>
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<tr>
<td>January 2018</td>
<td>35%</td>
</tr>
<tr>
<td>February 2018</td>
<td>43%</td>
</tr>
<tr>
<td>March 2018</td>
<td>34%</td>
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Inclusion services for children
For therapy services, including occupational therapy, physiotherapy and speech and language therapy, the number of children seen within the 18 RTT target were as follows:

Speech and language therapy:

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</thead>
<tbody>
<tr>
<td>Referral to first assessment</td>
<td>77%</td>
<td>77%</td>
<td>74%</td>
<td>72%</td>
<td>69%</td>
<td>69%</td>
<td>71%</td>
<td>70%</td>
<td>70%</td>
<td>74%</td>
<td>71%</td>
<td>69%</td>
</tr>
<tr>
<td>Referral to second assessment</td>
<td>68%</td>
<td>68%</td>
<td>64%</td>
<td>60%</td>
<td>55%</td>
<td>53%</td>
<td>53%</td>
<td>52%</td>
<td>51%</td>
<td>52%</td>
<td>50%</td>
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Occupational therapy:

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</tr>
</thead>
<tbody>
<tr>
<td>Referral to first assessment</td>
<td>59%</td>
<td>61%</td>
<td>59%</td>
<td>59%</td>
<td>56%</td>
<td>51%</td>
<td>46%</td>
<td>43%</td>
<td>40%</td>
<td>39%</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Referral to second assessment</td>
<td>48%</td>
<td>53%</td>
<td>51%</td>
<td>53%</td>
<td>51%</td>
<td>46%</td>
<td>42%</td>
<td>39%</td>
<td>37%</td>
<td>36%</td>
<td>38%</td>
<td>42%</td>
</tr>
</tbody>
</table>

Physiotherapy:
From the data provided by the trust, the RTT target of 92% was achieved on one occasion in March 2018 within physiotherapy. Occupational therapy performed the worst of the therapy services, achieving on average 45% against the 92% RTT target between April 2017 and March 2018 for referral to first assessment.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them. In some parts of the service it was not clear when and how lessons learned from concerns and complaints were shared with staff.

Complaints

Community services for children and families received the following numbers of complaints from January 2017 to December 2017:

The three departments/wards/teams with the most complaints were:

- **Community paediatrics** – 14 complaints
  
  Themes include:
  - Communication (nine complaints)
  - All aspects of clinical care (two complaints)
  - Handling of personal records (two complaints)
  - Failure to follow procedure (one complaint)

- **Paediatric speech & language therapy** – six complaints
  
  Themes include:
  - Information/communication with patients (four complaints)
  - Admission/transfer/discharge (one complaint)
  - Other, relating to waiting time delay in assessment (one complaint)

- **Health visiting** – four complaints
  
  Themes include:
  - Communication (two complaints)
  - All aspects of clinical care (one complaint)
  - Handling of personal records (one complaint)

(Source: Routine Provider Information Request (RPIR) – P61 Complaints tab)
Universal services for children
It was not clear when and how lessons learned from concerns and complaints were shared with staff from the health visiting service. Local leaders told us learning from complaints was shared at team, team leader and operational manager meetings. However, we saw no evidence of learning being shared in five of the six team meeting minutes or in any of the three team leader meeting minutes we reviewed. We did see evidence of complaints being discussed within the minutes of two operational manager meetings but there did not appear to be any discussion around learning.

Specialist services for children
Within the two child development centres (CDCs) we visited, we saw no information informing patients how to make a complaint to the service. There were no leaflets within information racks or posters on display in waiting rooms or consulting room.

Divisional leaders did offer us an example of how the service acted on feedback. A family had raised a concern that no specific parent and child parking space was available at one of the clinic sites, which meant carers often had to park on a main road. The service reviewed this feedback and implemented a parent and child parking space outside the clinic.

Nurses at a special school we visited in the south of the city showed us the complaints record on the trusts electronic records and reporting system. The team had no complaints during the three years prior to our inspection.

Compliments
The trust had reported a total of 28 compliments for community services for children and families.

The trust had not provided individual descriptions for compliments; however, at a trust wide level they have identified the main themes of all compliments as being:

- Praise for levels of care
- Caring attitude of staff – helpful, professional, kindness, compassion, patience
- Staff going extra mile
- Great service
- Quality of service
- Fantastic team
- Knowledgeable, experience, professional staff
- Felt listened to

(Source: Routine Provider Information Request (RPIR) – P62 Compliments tab)

Within the special school nursing service, we saw a sample of recent letters and cards from parents and carers giving very positive feedback to the nursing team.

Is the service well-led?
At our comprehensive Inspection of 2014 we rated leadership of the service as ‘Good’. At this inspection we have reduced this rating to Inadequate.

Leadership
The trust did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Universal and specialist services for children were provided and managed together within the children's and families’ division of the trust. The division was headed by the director of children
and families, a clinical director and divisional director nursing and therapies; supported by a deputy divisional director.

Divisional leaders told us they had good and open professional relationships with senior trust leaders. The visibility of leaders varied across the children and family services. Leaders did not always have the skills and knowledge needed to achieve clear oversight of all community services for children.

Universal services for children
Most staff within the health visiting service were aware of the senior managers within the children and families division and were aware of the management structure.

However, almost all staff were unaware of who made up the executive team. For example; very few of the operational staff from the health visiting service we spoke with, knew the names of the chief executive officer or director of nursing and therapies.

The team leaders and operational leads we spoke with had experience in health visiting and believed they were very knowledgeable about their teams and the service being delivered. However, we found in some respects this confidence was misplaced.

There was a clinical lead within the health visiting service that held responsibility for driving best practice and professional standards among health visitors.

Leaders understood the challenges to quality and sustainability, and could identify the actions needed to address them. However, we found they were not always aware of the performance of their teams.

Within the health visiting service, each operational manager and team leader we spoke with, identified the most significant challenge around delivering their service was staffing levels. They were aware of the actions being taken to address the challenge. We found leaders may not be aware of all the challenges to the service and it was unclear if they recognised this as a risk.

Leaders’ ability to have clear oversight of performance of staff and the service was compromised; there were issues with electronic systems and the effectiveness of anti-natal visit risk management varied between teams. Steps taken were not always ensuring consistent management of delivering safe care and treatment.

Health visiting service staff we met during our inspection visits were complimentary about their local leadership, commenting that team leaders and operation managers were supportive, approachable and visible. They also said they could arrange meetings with the head of service upon request. However, we were approached during the course of our inspection by two parties who were very aggrieved by how services were being managed.

Staff, particularly those working remotely, felt connected to other teams and sites within their service but not necessarily to the trust. School nurses and those within the health visiting service felt part of the children’s and families’ services but said they did not feel part of the trust.

School nurses told us they saw the senior managers within the division regularly and that they were approachable and supportive.

Specialist services for children
Nurses at the short break service were not immediately clear about the most senior role in the division or who was the Chief Executive of the trust, although remembered the new CEO had visited the unit. They knew the names of other divisional leaders and confirmed they worked alongside them to deliver the service.

Vision and strategy
The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. Some plans were not yet signed off by the trust board.

There was a clear vision and a set of values trust wide, with quality and sustainability as the top priorities. The values of the trust were: accessible, responsive, quality, caring, ethical and commitment.

Staff we spoke with were aware of these values and said they identified with them. They told us the values featured heavily in their supervision and they were expected to demonstrate how they were applied in practice. The trust and all the staff we spoke with were committed to inclusion; collaborating in providing what children needed to access school safely and regularly, despite their health needs.

Universal services for children

All staff within the health visiting service were aware of the vision for the service, although the time scale for completion had not been determined. Local commissioners had requested that the health visiting service be redesigned to align teams to council districts instead of GP practices. This request had been adopted by the health visiting service as their vision and at the time of our inspection, the process for implementation was being actioned. Many of the steps for reorganising their alignment were taking place but the process had not been completed and there was confusion amongst all levels of staff as to when it would be.

There was a realistic strategy for achieving the priorities for the health visiting service’s vision, which included a structured planning process in collaboration with staff, people who use services, and external partners. We saw evidence that the service had assessed and identified risks associated with the redesigned service and implemented actions to mitigate any potential issues.

We also saw evidence that the service had consulted all levels of staff and external partners. Staff told us they had been invited to numerous consultation meetings where they were able to provide feedback and concerns on the proposed changes to the service.

Specialist services for children

Staff described to us the trust value of inclusion; children were children first and disabled second. We requested and reviewed all strategies for children and family services. We found a strategy in place for:

- Early years (including health visiting)
- Specialist nursing services
- Community paediatrics
- Paediatric Sexual Assault Service (PSAS)
- Inclusion services (including speech and language therapy (SALT), physiotherapy and occupational therapy)
- Support services
- Two further strategies not related to specific services

We found seven of the eight strategies had been ratified within the trust. The inclusion services strategy provided by the trust was a draft, unratified version. We could not be sure therefore the trust had a dynamic strategy in place to address the concerns raised at the previous inspection.

None of the strategies had implementation dates so we were unable to measure progress against the one and two-year objectives.

The specialist nursing strategy had two objectives that would increase pressure on children’s community nursing teams. They were:
The implementation of a rapid response team within the community to help prevent admissions to an acute setting.

A review of all children and young people within local authority run care homes for looked after children and for nursing teams to review children under five to relieve pressure on the community paediatricians.

However, only one of these strategic objectives noted the need for a business case to be developed in order to support the change and expansion of services. This raised the probability of current pressures on community nursing teams increasing without additional resources becoming fully embedded first.

During the inspection senior leaders told us business cases had been put forward for increased staffing within teams to meet the demands of the service. We requested any current business cases in relation to increased staffing for:

- Children in care team (CiC)
- Speech and language therapists (SALT)
- Occupational therapists (OT)
- Physiotherapists
- Child development centres (CDC)

The trust provided business cases for SALT, CDC and CiC.

The business plan for increasing staffing within the SALT team from January 2018 was detailed and complete, highlighting multiple options with risks and benefits of each. This plan was under consideration by the trust at the time of our inspection.

The business case provided by the trust in relation to the CiC team was draft, incomplete and lacked specific details. We could not be sure the trust had approved funding to ensure the CiC team had sufficient resources to meet the demands of the service. Leaders couldn’t give a timescale in which the business plan would be complete and submitted for review. We have asked the trust to provide us with firm and timely assurance about this.

The business case in relation to development pathways within CDC was incomplete, missing details and clearly still at the author stage. Areas incomplete on the business plan included: preferred outcome or option, staff allocated to lead on specifics of the project and the internal project reference numbers. From the draft nature of the document and missing information, we concluded this business plan had not been fully reviewed and submitted for board approval. We could not be sure of the timescale in which the business would be complete and submitted for review.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Most staff we spoke with told us the culture within community health services for children and families encouraged openness and honesty at all levels. This included with people who use services, in response to incidents. A few staff told us they had experienced very negative responses from local managers when they spoke up about concerns.

Staff were aware of the duty of candour and could tell us when it would be applied. The duty of candour 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 person. We noted an example of the duty
of candour being exercised appropriately at the very onset of a serious incident investigation that occurred in April 2018.

Leaders and staff told us they understood the importance of staff being able to raise concerns without fear of retribution. Staff we spoke with told us there were no barriers to reporting an incident. Most told us if they raised a concern they felt supported by their line manager when the need to highlight a concern arose.

During the process of our inspection however we were approached on three occasions by individuals and groups of staff who were angry about their treatment when they had spoken up about poor practice or the behaviour of colleagues or discrimination. We are in continuing communication with the trust over this.

We also found the effectiveness and safety of lone working arrangements differed across services in health visiting despite concerns raised by staff. We have brought this to the attention of the trust and they have given us an action plan for improving this situation.

Universal services for children
Within the health visiting service, all team leaders and operation managers we spoke with described how proud they were of staff who delivered the best service they could against the pressures of high demand. All staff we spoke with during our inspection visits were proud of what they did and felt supported. Staff said they felt positive about the organisation and were able to challenge ideas. Others have since contacted us anonymously to tell us they do not feel supported.

Most staff within the health visiting service felt respected and valued. Staff told us team leaders had been supportive of them when they had experienced difficulties in their professional and personal lives.

There was a strong emphasis on the safety and wellbeing of staff within the health visiting service. Health visiting staff explained their process for checking with colleagues before and after patient visits and told us they felt it worked well. Staff said they felt their safety was effectively promoted. Staff calendars were electronic and could be accessed by colleagues and teams leads to ensure their location was known.

However, most health visiting teams relied on their paper diaries. Some staff used text messages or called each other to confirm that they were safe at the end of the day. Others told us a code word was used to establish if someone working alone was unsafe and staff could tell us about this process and code word. If there were any specific families who had been assessed as being a potential safety risk an alert was put on the electronic patient records system and those families were invited to clinics instead of having home visits. Staff also received conflict resolution training.

Central booking service staff told us the trust was now transparent with service data and staff could see the dashboard of target delivery and breaches and this made them feel included and engaged.

Specialist services for children.
Throughout our inspection visits we found a culture of inclusiveness, openness and honesty. All staff we asked spoke highly of local leadership and spoke of an ‘open door’ policy in relation to raising concerns.

We found a culture across all areas looked at that put the child or young person and their family at the heart of the care provided, despite the challenges faced in relation to low staff numbers and high caseloads.

However, we found a mixed approach to the support and information offered to patients in relation to the protected characteristics of the Equality Act (2010). The Equality Act (2010) covers
the following nine protected characteristics: sex, sexual orientation, race, pregnancy and maternity, age, disability, religion or belief, gender reassignment and marriage and civil partnership status.

**Governance**

**The trust used a systematic approach to continually improve the quality of its services.** It was not clear how effective structures, processes and systems of accountability were.

There were some structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Within the division there were staff forums where information regarding performance, challenges to the service and learning was shared. For example, there were forums for school nursing, band five nurses and administration staff.

However, it was not clear how effective structures, processes and systems of accountability to support the delivery of the strategy and good quality services were.

**Universal services for children**

Within the health visiting service, operation managers held monthly meetings. These were attended by the operational managers within the service and were chaired by the head of early year’s health and wellbeing service. The purpose of the meetings was to share information related to the health visiting service, which included but was not limited to staffing, training, quality and performance data, incidents, complaints and risk.

Local leaders told us operation managers were also able to escalate specific issues, related to the service, to the head of early year’s health and wellbeing for discussion at higher level governance meetings. The meetings were minuted and circulated to attendees. We reviewed three sets of minutes and all differed in terms of detail and discussion topics. There appeared to be focus on staffing and training but discussion around quality and performance was limited.

Leaders told us there were monthly team leader meetings which were attended by the team leaders and their operational manager. The purpose of these was to cascade information from the operational managers and escalate information from the team leaders. We reviewed three set of minutes from meetings in February, March and April 2018. The meetings followed a standing agenda which included discussion on staffing, training, quality and performance, incidents, risk management and safeguarding. The level of detail recorded for each agenda item differed and it was not always clear what was discussed. For example, quality and performance contained no detail on whether the health visiting teams were meeting their key performance indicators.

Each health visiting team were supposed to hold monthly team meetings. Attendees included team leaders, health visitors, assistant practitioners and administration staff. We reviewed six sets of minutes from two health visiting teams and saw that agendas differed amongst teams but shared some common themes including staffing and training. Both health visitors and assistant practitioners told us the team leaders used the meetings to cascade information they had received from their operational managers and we saw evidence of this in some of the minutes were reviewed. We were told by staff that the minutes from meetings were circulated by email. However, there were teams who had not had team meetings monthly. For example, staff were due to attend a meeting on a day of our inspection but told us they had not had one for three months.

**Specialist services for children**

Local managers within complex care services, short break service and specialist school nursing told us the trust had good systems to support governance.

**Management of risk, issues and performance**

**The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
The trust had a risk register for the children and family’s division services. We saw evidence of risks being recorded on risk registers but it was not clear when or where they were reviewed. However, not all potential risks were included, so there was no evidence of management of these. Investigations of serious incidents did not include broader, systemic factors that may have contributed, so learning was limited. Risk management was not robust and we are in continuing contact with the trust about this.

Universal services for children

We found health visitors were not notifying other professionals of their unallocated antenatal referrals. Local leaders told us data on the number of unallocated referrals had been collected and collated in the past but at the time of our inspection this practice had ceased. There was no data available of the number of referrals which had not been allocated or the reasons why the visits were not carried out. This meant the trust could not assure itself risk was being well managed.

Within the health visiting service, it was unclear to us whether there were comprehensive assurance systems or if there were clear structures and processes for escalating performance issues. It was also unclear as to how the health visiting service was monitoring its performance. There were arrangements for identifying, recording and managing risks, issues and mitigating actions but we could not be clear how effective these systems were.

Discussion regarding performance within the health visiting service was an agenda item at monthly operation managers meetings. We reviewed three sets of operation manager minutes from August 2017, February and April 2018. However, the minutes we reviewed did not contain much detail on performance. In each set, key performance indicators (KPIs), relating to the five key contacts, did not appear to be discussed in detail. Within the April 2018 minutes, it was noted that a health visitor provider performance report had not been received for “a number of months”. Within the February 2018 minutes, it was noted that the data on the electronic system for monitoring KPIs “has been incorrect”. Within the August 2017 minutes, the health visitor provider performance report was an agenda item but there was no detail on what was discussed. It was not clear from any of the minutes whether these issues had been escalated or who was going to escalate it.

There was no systematic programme of clinical and internal audit to monitor quality, operational and financial processes or systems to identify where action should be taken. We saw evidence that the only clinical audit the health visiting service undertook was a patient records audit, which was conducted on an annual basis. We did not see the most recent record keeping audit which took place in 2017 but the results were discussed during a health visitor service operation managers meeting. The audit had identified some positive practice but also areas of improvement, which were going to be analysed further and fed back to the health visiting teams.

There was a separate risk register for the health visiting service and we saw evidence that risks had been rated and actions introduced to reduce the impact of the risk. We discussed which risks the operation managers and team leaders thought were most significant during our inspection visit and their views were in line with what was outlined on the risk register.

Health visitors and assistant practitioners were aware there was a risk register but could not tell us definitively what the highest risks were. The operations managers, team leaders and operational staff told us that the main risk to the service was staffing levels, which was rated as moderate on the risk register. We reviewed three sets of operation manager meeting minutes and saw that risk was an agenda item but the detail on what was discussed was limited.

Within the August 2017 minutes, there was no detail on what was discussed and the February 2018 minutes only mentioned “staffing”. The April 2018 minutes were more detailed and classified staffing as a “major” risk, although, on the risk register it was classified as a moderate risk. It was not clear to us from the minutes if the risk register was reviewed at every meeting or if the risk
register was updated to reflect any escalation in risk. We were offered no evidence that service specific risks were discussed at team level.

As described above, the system for monitoring the health visiting service performance was not recording data correctly; however, this issue was not identified, recorded or managed as a risk to the service. In its urgent response plan to the concern we raised over this issue during our inspection visits, the trust confirmed this.

Although local leaders told us it had been a problem for some time, the short fall in ante-natal visits had been added to the risk register as recently as 17 May 2018. The trust had outlined mitigating actions. These included but were not limited to, prioritising antenatal visits according to capacity, with clinical rationale and liaising with the maternity services if concerns were raised. However, the effectiveness of the trust’s strategy appeared to rely on other healthcare providers. This was not reliable as staff within the health visiting service told us that communication between their service and the midwifery service was not always effective.

**Specialist services for children**

Local leaders were aware of the divisional risk register and told us they could escalate matters of concern through the governance structures to be managed by the register. We noted there were items on the risk register at the time of our inspection, relating to specialist services for children.

The trust had responded to the difficulty it had experienced in recruiting experienced nurses for the complex care and community and school nurse services. Managers told us the plan was to increase the staffing numbers to enable a newly qualified nurse to undertake 6-month rotations shadowing experienced staff. A preceptorship programme was planned.

We requested the lone working policy, risk assessments and standard operating procedures (SOP) for staff within the complex care team (CCT). The CCT undertook home visits to provide care within the homes of children and young people with multiple and profound disabilities. This included day and night shifts. The trust sent us SOPs and risk assessments for health centres and health visiting teams. However, they did not provide information on the CCT. We found the CCT did not have a system in place to ensure staff had left visits safely, particularly late at night or where there was an increased risk of aggression or violence.

The trust’s lone working policy, last updated February 2018, stated as a minimum all solitary workers should “include at least a check in at the end of the working period” to ensure their safety and welfare. However, we found the CCT did not ensure this happened. The lone working policy also stated that following a visit staff should “let their manager or colleague know that they are safe”. The CCT leaders told us this did not happen.

We found 32 out of 61 support workers had not been issued with a trust mobile telephone, or any other form of communication. This presented a risk to the safety of staff while they were mobile working as they had no form of communication issued by the trust, to raise concerns or ask for help. This was not in line with the trust’s lone working policy.

The lone working policy stated staff who lone work should be risk assessed for the need to be issued with a lone working device. These were devices that could be used to alert a call centre discreetly should a member of staff be in danger or require assistance urgently. Senior CCT staff told us that no risk assessments had been undertaken. The adult community nurses had been issued with the lone working devices but no reason was given by the trust as to why children’s services had not been issued with them. These concerns already raised by staff, had not been escalated to the local risk register for the children in care team. We raised this with the trust after our inspection visits. The trust sent us an urgent assurance plan for how it intended to address this.

The divisional risk register included the risk of significantly lower number of staff within the children in care team than recommended by the Royal College of Paediatric and Child Health (RCPCH) in 2015. The RCPCH recommends a case load of 1 practitioner to 100 children. At the time of our
inspection the trust had 1 practitioner to 600 children in care. This had been rated on the trusts risk register as a major risk.

However, we found the controls identified on the risk register limited. These were: liaise with multiagency safeguarding hub to identify risks, liaise with education, children’s homes and carers to ensure children and young people’s needs are communicated and commence 0.5 whole time equivalent nurse to run drop in sessions to increase access to services. The latter is unlikely to have significant impact on the scale of the problem.

Children and family services did not participate in the trust essential care indicators audits. This meant the senior leadership team did not have oversight of the performance of children’s services in the same detail as other services across the trust.

We did not feel confident that local senior leaders and the trust wide board had a grip on the risks and performance within community services for children. It was unlikely therefore they could provide the support required to improve these services.

Our last inspection in 2014 required the trust to make improvements in the responsiveness of services to children and families:

- Some services failed to meet the 18-week referral to treatment time pathway and children did not receive timely intervention; most notably the occupational therapy and speech and language therapy services.
- Children did not have timely access to speech and language interventions
- Transition services were poorly managed as there was a lack of arrangements in place for those young people who were due to transfer into adult services.

The trust sent us action plans for improvement. Although this inspection of 2018 found improvements in some areas, these issues remain largely unresolved and we found additional areas of concern about the responsiveness of these services.

**Information management**

The trust collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. Information technology systems were not always used effectively to monitor and improve quality of care.

There were arrangements in place to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

Staff received training on information governance as part of their mandatory training. According to data from April 2017 to December 2017, compliance with information governance training amongst doctors and nurses was at 97% and 96% respectively, which was above the trust target of 95%.

This was an improvement from our last inspection in 2014 where we said the trust should improve access to training for the staff using the new electronic records system. Services were using an electronic patient record system to record data. The system was secure as each member of clinical staff had a personal log-in and password, which meant access to the system was restricted. If paper records were produced they were scanned onto the electronic system and then archived.

However, information technology systems were not always used effectively to monitor and improve quality of care.

Staff had their own trust email account and received regular updates on training courses they could attend and could view when their mandatory training was due or had expired. Staff also had access to a personal electronic personal development page on the trust’s intranet, where they could access training and review their personal performance records. There was policies, practices and guidance using the intranet while at locality bases.
The trust’s electronic system for monitoring, recording and reviewing the performance of the health visiting teams was not accurately reporting data. The health visiting service was also unable to use the system to review all the performance data related to the five key contacts within the healthy child programme. Managers at the Child Health Information Service (CHIS) told us trust practitioners could access CHIS records with a smart card to view information managed through this ‘fail safe’ system. It was not clear why CHIS and other electronic systems were not interrogated for useable data, not reporting data accurately nor why the performance data on all the five key contacts could not be reviewed by senior leaders. Team leaders had not received reports on their team’s performance for a number of months.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

People’s views and experiences were gathered and acted on to shape and improve services and this included feedback from children and young people who used them.

The school nurse service had introduced the school nurse ambassador programme in March 2015, which allowed children from secondary schools, to be nominated by their schools to act as liaisons to the school nurses. As part of the programme, the children were involved in projects designed to raise awareness of the school nursing services within their schools. As school nurse ambassadors, they were invited and attended event days where they could contribute ideas to how the services in their schools could be improved.

Examples of improvements made as a direct result of the contribution from school nurse ambassadors included; changes in the feedback survey questionnaires to make them easier to understand, introduction of posters advertising drop-in sessions, posters detailing step-by-step information on immunisations and the introduction of school nurse details in pupils’ planners.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.

The school nursing service was going through a decommissioning process at the time of our inspection. During this time staff had been invited to relevant meetings regarding the process and updated on any developments. Staff said the trust had been very open and kept them informed on service planning going forward.

The health visiting service was also being restructured and the trust had arranged for consultation meetings for staff. Staff within the service said updates on developments had been sent out my email and on the trust’s intranet. Staff had been asked for their preferences on where they would like to work, following the change to geographical working.

The trust was at an advanced stage of working with partner stakeholders in the City, planning strategies for transition arrangements for children with additional and complex needs, to move to adult services.

The children in care (CiC) team used service users to interview applicants who applied to join the team. The CiC told us this allowed the service users voice to come through strongly and create trust within young people that the service was designed with their needs in mind. The young people’s input carried 50% of the weight in any decision to employ a candidate.

Learning, continuous improvement and innovation
The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The therapies teams within the children and families service were working with local Clinical Commissioning Groups (CCGs), responding to complaints about which children could be treated within the constraints of the services that were commissioned. This aimed to promote a more open and transparent response to families.

The children in care (CiC) team had developed a health passport for children and young people over the age of seven years. Children could use this to record all aspects of their health and healthcare needs. The trust planned to implement this on 1 June 2018 so we did not see it in practice.

The complex care team had worked with services users and carers to develop a range of feedback cards specifically for different ages and developmental states. For example, easy read cards free of jargon for young people with Downs Syndrome to encourage and promote their ability to give feedback on the service. Other feedback cards had spaces for service users to draw rather than write an answer. These feedback cards had been in place a several months and the services said they had received good feedback from service users and carers.

We saw these in use within the mainstream school nursing service where school nurse ambassadors confirmed they had been involved with designing them for their schools.

At the children’s short break service one member of staff told us they had been supported to redesign the medication administration record (MAR) sheets and drugs cabinets. This included moving from one drugs cabinet to a trolley with individual locked drawers with pictures of each room theme. Each MAR sheet was printed with the child’s medications and featured the child’s photograph. This aided bank staff in recognising the child and reduce identity risk. Staff told us this had reduced the number of medication errors and the time taken to administer medication therefore improving timeliness of doses.

Accreditations

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

(Source: Routine Provider Information Request (RPIR) – Accreditation tab)
Facts and data about this service

Details of the locations at the trust that offer community inpatient services are below.

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team/ward/satellite name</th>
<th>Patient group</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moseley Hall Hospital</td>
<td>Nursing and therapies urgent care</td>
<td>Mixed</td>
<td>118</td>
</tr>
<tr>
<td>Ann Marie Howes</td>
<td>Nursing and therapies urgent care</td>
<td>Mixed</td>
<td>32</td>
</tr>
<tr>
<td>Perry Tree Centre</td>
<td>Nursing and therapies urgent care</td>
<td>Mixed</td>
<td>32</td>
</tr>
<tr>
<td>Community Unit 27</td>
<td>Nursing and therapies urgent care</td>
<td>Mixed</td>
<td>28 (can increase to 33 during the winter period.)</td>
</tr>
<tr>
<td>West Heath Hospital</td>
<td>Nursing and therapies urgent care</td>
<td>Mixed</td>
<td>58</td>
</tr>
<tr>
<td>Riverside Lodge</td>
<td>Learning disabilities (specialist services)</td>
<td>Mixed</td>
<td>8</td>
</tr>
<tr>
<td>Kingswood Drive</td>
<td>Learning disabilities (specialist services)</td>
<td>Mixed</td>
<td>6</td>
</tr>
<tr>
<td>Edgewood Road</td>
<td>Children's &amp; families’ division</td>
<td>Mixed</td>
<td>6</td>
</tr>
</tbody>
</table>

**Moseley Hall Hospital (MHH):**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 5 sub-acute medicine</td>
<td>26</td>
</tr>
<tr>
<td>Ward 6 sub-acute medicine</td>
<td>28</td>
</tr>
<tr>
<td>Community Clinical Decision Unit</td>
<td>12</td>
</tr>
<tr>
<td>Ward 8 (stroke and rehabilitation)</td>
<td>28</td>
</tr>
<tr>
<td>Ward 9 (INRU)</td>
<td>24</td>
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**West Heath Hospital (WHH):**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 12 Trauma &amp; Orthopaedics</td>
<td>20</td>
</tr>
<tr>
<td>Willow House Intermediate Care</td>
<td>18</td>
</tr>
<tr>
<td>Sheldon Unit Palliative EOL</td>
<td>20</td>
</tr>
</tbody>
</table>

**Good Hope Hospital (GHH):**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Unit 27 Enhanced Assessment</td>
<td>28 (Can increase to 33 during the winter period)</td>
</tr>
</tbody>
</table>

**Ann Marie Howes (AMH):**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Marie Howes Intermediate Care</td>
<td>32</td>
</tr>
</tbody>
</table>
Birmingham Community Healthcare NHS Foundation Trust offers community and specialist services within Birmingham and the West Midlands. They deliver over 100 clinical services, out in people’s homes and in over 200 sites including hospitals, health centres and clinics. They provide services for adults, children, people with learning disabilities, those with rehabilitation needs and dental services. BCHC delivers community based health care services to people of all ages across Birmingham. This covers a population of approximately one million and a geographical area of 103 square miles, including Birmingham, Sandwell, Dudley and Walsall. The trust also delivers specialist rehabilitation services for the Warwickshire, Staffordshire, Worcestershire, Shropshire and Herefordshire. Specialist rehabilitation services are mainly provided at three sites including West Midlands Rehabilitation Centre at West Heath Hospital and at Moseley Hall Hospital.

A wide range of services are provided for people living in all parts of the West Midlands to assist them in managing disabilities. The comprehensive range of services is for people with physical, cognitive, emotional and social disabilities offering personalised, integrated services that best meet the needs of individual patients and their carers.

Services at the West Midland Rehabilitation Centre include regional posture and mobility centre, Birmingham wheelchair services, access to communication technologies, environmental controls and augmentative and alternative communications, specialist orthotics an amputee rehabilitation services and clinical measurement laboratory.

Services at the Moseley Hall Hospital include an Inpatient Neuro-Rehabilitation unit, Moor Green vocational services, Birmingham Neuro Rehabilitation Team, Brain Injury Specialist Clinic and Community Stroke Service in addition to rehabilitation wards and a Community Clinical Decision Unit (CCDU) which provides assessment and admissions services for older people.

We visited four of the community inpatient locations:

At West Heath Hospital we visited two of the inpatient wards. The wards had both male and female bays with 58 beds in total. We visited Willow House, a dementia friendly unit and ward 12, a general rehabilitation ward. The wards had their own multidisciplinary team including nurses, doctors, physiotherapists, occupational therapists, social workers, rehabilitation assistants, domestic staff and housekeepers. There was also provision for patients to access speech and language therapy, specialist nursing and dietetics.

We visited the Perry Trees Rehabilitation Centre which had both male and female bays with a total of 32-beds. The multidisciplinary team consisted of a clinical lead, nurses, healthcare assistants, occupational health, physiotherapy, GP service, social worker, consultants from a neighbouring Birmingham trust, housekeepers, domestics and administrative staff. Any adult aged 18 and above can access this service if they are registered with a Birmingham GP and have a level of cognitive ability to be able to participate in rehabilitation.

We visited the enhanced assessment bed service (ward 27) at Good Hope Hospital, a 28-bed ward with both male and female bays. This unit offered enhanced assessment to patients who are medically fit for discharge from an acute hospital bed, but are unable to return to their place of residence due to a change in their health or social function. The unit offers a multi-disciplinary assessment to patients and families to support life changing decisions on their future place of residence or the support that they will need to return to their own home. The ward could increase

<table>
<thead>
<tr>
<th>Ward</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perry Tree Centre Intermediate Care</td>
<td>32</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Sites tab)
capacity up to 33 beds during the winter period. The service is for adults aged 65 and over and they can access this service if they are registered with a Birmingham GP.

Patients were discussed daily with the multidisciplinary team and weekly with the consultant. The multidisciplinary team consisted of nursing and health care staff, senior occupational therapists, a senior physiotherapist, a therapy assistant practitioner, visiting GPs, two senior geriatric consultants and two social workers. Referral to specialist services can also be made to enhance assessment and ensure the right services are involved in the discharge pathway.

The referral process for the enhanced assessment bed service (ward 27) at Good Hope Hospital through the acute hospitals electronic referral system called transfer of care. Referrals can also be made from the assessment units of the acute hospital by either telephoning the unit or contacting the intermediate care liaison nurse Monday to Friday 8am to 4pm based at Good Hope Hospital.

We inspected Moseley Hall Hospital and while there visited all inpatient wards. The ward had 118 beds and had both male and female bays. The team provide a short-term community based rehabilitation programme for older adults living with dementia, adults with neurological problems, such as brain injury, stroke and multiple sclerosis. The teams were multidisciplinary and in addition to doctors and specialist nursing staff consisted of speech and language therapists, physiotherapists, occupational therapists, consultants in rehabilitation medicine, rehabilitation assistants and clinical psychologist.

There was a general rehabilitation unit, a specialist stroke rehabilitation unit for adults who are recovering after stroke, a specialist assessment and intensive rehabilitation for people with disabilities resulting from neurological conditions.

Any health or social care professional, carers, voluntary agencies or patients themselves can make a referral into this service.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During the inspection, the inspection team:

- Spoke with 30 patients and 13 visitors of those who were using the service.
- Spoke with four senior managers, three consultants, four clinical team leaders, four matrons, six speech and language therapists, four physiotherapists, two occupational therapists, one lead allied health professional, one pharmacist, 13 healthcare assistants, one consultant therapist, 24 nurses, two rehabilitation assistants and one student nurse.
- Reviewed 14 sets of patient care records.
- Observed board rounds, handovers, staff safety huddles, and multidisciplinary meetings and had a tour of each ward environment.

The Care Quality Commission previously carried out a comprehensive inspection between 23 and 27 June 2014, which found that overall, the trust and this service had a rating of 'good'.
Is the service safe?

At our Comprehensive Inspection of 2014 we rated leadership of the service as ‘Good’. At this inspection we have reduced this rating ‘Requires Improvement’.

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it. This meant the service could not assure itself that staff working in the inpatient units had the skills essential and necessary for the safe and efficient delivery of services.

Staff were provided with a regular cycle of mandatory training to assist them in achieving the standards of patient care expected. We looked at compliance with mandatory training across each site visited and saw that there were systems in place to monitor timely completion.

However, staff did not always find that mandatory training was accessible despite having protected time to complete it. We saw documented protected learning time scheduled in staff electronic records. Some of the mandatory training targets were not met due to the lack of availability of dates. Some training was provided off site and staff who could not drive were sometimes unable to access this training. Staff working on flexible days told us it could be hard to fit training in.

Some staff found using technology to access training difficult. We asked managers about their plans to improve accessibility and were told that they had introduced measures to support staff. This included offering one to one support for those who found technology difficult to navigate. They were also planning to use closed wards on the hospital grounds to deliver training courses locally, for example, manual handling.

Those staff who had not completed their training were either booked on to the training or staff on long term sick would complete the training when they returned. This meant that there was a commitment from managers to ensure that mandatory training was accessible.

Mandatory Training completion

The trust set a target of 85% for completion of most mandatory training courses, except for Information Governance, Child Protection Level One and Safeguarding Adults Level One which all had a completion target of 95%. A breakdown of compliance for mandatory courses from March 2017 to April 2018 for medical/dental and nursing staff within community inpatient services is below.

Medical and dental staff

There were ten key modules listed in the mandatory training matrices. In two out of eight subjects the compliance level for medical and dental staff met and exceeded the trusts target. In four out of the ten, compliance was lower than the trusts target but was close to meeting at 70% to 80%. Medicines management training had 33% compliance which fell far below the trust’s target. This meant not all staff were trained to required level to ensure patients received safe care and treatment. Following our inspection, the trust advised us that as at end of June 2018, compliance had risen to 67%. We were also advised that the divisional leadership team had a plan in place to ensure all eight doctors who had not completed the training would do so by 30th September 2018. The trust also assured us that nursing staff were at a 92% compliance.
<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff last year</th>
<th>% Completion</th>
<th>Trust Target (%)</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying &amp; Harassment</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT/Wrap</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>6</td>
<td>10</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>6</td>
<td>10</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus</td>
<td>6</td>
<td>10</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>3</td>
<td>9</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust data return DR3)

Please note, as the total number of eligible medical staff is small, each staff member accounts for a larger percentage than nursing staff within the same service.

**Nursing staff**

There were 11 key subjects listed in the mandatory training matrices. In six out of 11 subjects the compliance level for nursing staff met and exceeded the trusts target. The remaining five modules compliance was lower than the trusts target but was close to meeting. This meant not all staff had received compulsory training that was determined essential by the trust for the safe and efficient delivery of services.
<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff last year</th>
<th>% Completion</th>
<th>Trust Target (%)</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying &amp; Harassment</td>
<td>196</td>
<td>196</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT/Wrap</td>
<td>193</td>
<td>196</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>188</td>
<td>196</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>154</td>
<td>173</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>112</td>
<td>128</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>170</td>
<td>196</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>165</td>
<td>196</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus</td>
<td>162</td>
<td>193</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>157</td>
<td>196</td>
<td>80%</td>
<td>85%</td>
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</tr>
<tr>
<td>Infection Control</td>
<td>17</td>
<td>23</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>134</td>
<td>196</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust data return DR3)

**Safeguarding**

Staff we spoke with understood how to protect patients from abuse, however, not all eligible staff had completed training on how to recognise and report abuse. The trust had not provided staff with child protection level 2 training as mandated in the safeguarding intercollegiate document.

The adult safeguarding policy was up to date and set out the statutory requirements for staff to discharge its appropriate accountability for safeguarding children, young people and adults at risk of harm or abuse.

All staff we spoke with had a good understanding of the principles of safeguarding, including warning signs of abuse such as unexplained bruising and suspicious behaviour. Staff knew how to contact the trust’s safeguarding team and could give examples of the kind of safeguarding referrals they had or might make.

The trust had a corporate safeguarding team, with a head of safeguarding for operations and a professional lead who managed safeguarding partnerships. There was a total of eight safeguarding leaders who worked Monday to Friday. There was a five-day safeguarding service, 9am to 5pm duty and advice system that all staff could ring. Out of hours, staff could contact the Adults and Communities Access Point Emergency Duty Team (ACAP EDT).

All alerts raised were dealt with and shared with the team. There was a database where advice, deprivation of liberty safeguard applications and safeguarding alerts raised for adults were logged and reported bimonthly to the safeguarding advice committee. Staff who raised a complex safeguarding alert were offered a supervision session. The trust carried out a quarterly survey to evidence staff attendance at safeguarding adults’ reflective supervision sessions. The survey
carried out in 2017/18 demonstrated that between January 2018 and March 2018, 62 referrers of safeguarding adult alerts were invited to attend a reflective supervision session and received a survey. Of the 62, 26 attended a session and 19 completed a survey. All of those that completed a survey, confirmed they had received an invitation to a session and that they attended one.

There was an extensive intranet area on safeguarding which was two clicks away from the front screen for ease of access. This was where staff could access information relating to safeguarding and who to contact. The safeguarding adults team provided a duty service for staff for support in safeguarding adults cases.

The safeguarding lead told us that to assess responsiveness the team carried out surveys. For example, they monitored how quickly the telephone was answered and how quickly the enquiry was dealt with. The safeguarding team shared audit findings with safeguarding boards and the adult subcommittee. For example, an audit was completed in 2015 on staff knowledge of who to contact following concerns and how to raise a safeguarding adult Alert and staff knowledge of who to contact for Deprivation of Liberty Safeguards (DoLS) authorisations and benefits of the DoLS legislation. Both audit reports were presented to Safeguarding Adults Sub-Committee in November 2016 and updates were given to Clinical Governance Committee in December 2016.

Staff attended local serious case reviews which included domestic homicides for learning and revalidation for nurses. Staff were proactive on the workstreams for the safeguarding adults board, there was also a partnership workstream and task and finish groups. This meant that there were several forums where staff made contributions to local safeguarding arrangements.

Agency and bank staff had a local induction which included safeguarding adults and children training. This meant that all staff working on the wards were trained to ensure they could identify and respond to safeguarding concerns. Staff provided us with examples of when they had made safeguarding referrals, what support they received and what the learning was and changes made to practice. We were told that social workers could and did attend ward meetings when appropriate. This meant they worked jointly to improve outcomes for patients who may have safeguarding concerns.

Safeguarding Training completion

The trust set a target of 95% for completion of Safeguarding Adults Level One and 85% for Safeguarding Adults Levels Two and Three. We compared the trusts internal safeguarding targets with six of our next phase inspections that included community health services for children and families and/or Community health services for adults and have found varying target data between 85% and 95%. This showed the trust had set safeguarding training completion targets at the lowest comparative figure.

A breakdown of compliance for safeguarding courses from March 2017 to April 2018 for medical/dental and nursing staff within community inpatient services is below:

Medical and dental staff

The trust provided data for three safeguarding training modules. In all three modules the trust was below their target for compliance for medical and dental staff, with two modules having 60% compliance. This meant the trust could not assure themselves medical staff were able to protect people’s health, wellbeing and human rights, and enable them to live free from harm, abuse and neglect.
Medical staff had not received child protection level 2 training which is required for those staff who have regular contact with parents, children and young people. This meant the trust could not assure themselves medical staff were able to recognise child abuse and document their concerns, know who to inform and fully understand the next steps in the child protection process.

Nursing staff

Nursing staff within community inpatient services met the completion target for one of the four safeguarding training modules made available to them. The remaining three modules compliance were lower than the trusts target but were close to meeting. This meant the trust could not assure themselves nursing staff were able to protect people’s health, wellbeing and human rights, and enable them to live free from harm, abuse and neglect.

(Source: Trust data return DR3)

Nursing staff had not received child protection level 2 training which is required for those staff who have regular contact with parents, children and young people. This meant the trust could not assure themselves medical staff were able to recognise child abuse and document their concerns, know who to inform and fully understand the next steps in the child protection process.

Following our inspection to ask for assurance regarding the lack of child protection level 2 training for staff. The trust replied that they had carefully reviewed the Intercollegiate guidance (2014) and considered the CQC Safeguarding children training transition position statement (February 2018) and had developed an action plan.
Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority had their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern was raised regarding a child or vulnerable adult, the trust will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

All safeguarding referrals were recorded, audited and reviewed by the safeguarding team who spoke directly with those involved. This was to ensure reflection and learning. This learning was shared with all staff. There were two social workers based on the enhanced assessment bed service (ward 27) at Good Hope Hospital Monday to Friday who worked directly with staff and patients to manage any safeguarding issues. Staff attended joint meetings for the protection of patients and at a senior level, safeguarding leads were involved in local authority meetings, committees and reviews to ensure information and learning was shared in a wider sense.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Domestic services were provided differently across sites. For example, at the Perry Trees Centre, estates and facilities at the local authority provided cleaning services. The clinical team leader informed us that they were unhappy with the standard of cleanliness and that they had a meeting planned to discuss options for improvement with the local authority. Perry Trees Centre was visibly clean; however, there were regular gaps in the checking system which might mean areas were not being regularly cleaned.

The trust had lead infection control nurses and link nurses. Quarterly meetings were held to update link nurses on best practice and any developments or changes to policies.

Lead infection control nurses, link nurses or nominated nurses carried out a cleaning audit every month on every ward. They identified issues, tracked, monitored and identified action plans. These staff had completed a relevant four-day training course.

Each ward displayed infection control audit outcomes on quality boards. All boards indicated meeting targets for infection control and cleaning audit results. For example, people on the ward could see the results of infection control audits, which on the sub-acute medicine ward at Moseley Hall Hospital was 100%. The Trust improved the standards of cleanliness throughout the in-patient units. They achieved full compliance against the National Specification of Cleanliness (2007) throughout 2016/17 which was published in their infection and prevention control annual report. This meant that staff were focussed on the principles of the prevention of spreading infectious diseases.

Hand hygiene audits (the Lewisham tool) were carried out across the trust’ inpatient areas and the compliance score was set at 95%. The trust achieved compliance each month during 2016/17. The audit involved the infection prevention control nurse observing practice in each inpatient area every month. The advantage of this approach was that the nurse could provide ad hoc training to staff if non-compliance was observed and real-time feedback was given to those involved.

Moseley Hall Hospital was clean and there were domestic staff who worked on the wards to ensure they were well maintained. However, on ward 9, the neuro rehabilitation unit, the garden was untidy with litter. We asked the nurse in charge about who was responsible for cleaning the
garden and were told that staff on the ward took responsibility for keeping it clean in addition to their duties with patients. This might mean that the space was not therapeutic or pleasant for people to use. There were many gardens throughout the rest of the hospital, all of which appeared clean, tidy and well maintained.

PLACE Assessments

These self-assessments are undertaken by teams of NHS and private/independent health care providers, and included at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The 2017 PLACE score for:
- **Cleanliness** at the trust was 99.3% which is about the same as the England average overall of 98.4%.
- **Facilities** at the trust was 92.4% which is lower than the England average overall of 94.0%.

Please note, due to a lack of information, the England average overall score includes all trust types and is not limited to community trusts only.

(Source: Patient Led Assessments of the Care Environment (PLACE))

Environment and equipment

The service had suitable premises and equipment and looked after them well.

There were systems in place for managing waste and clinical specimens across all locations. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.

Storage and space to keep equipment safely stored was at a premium on some wards. For example, at Perry Trees Centre, storage space was very limited. Most of the equipment needed for patients was stored in corridors. The matron told us that they were restricted by the fact that the local authority owned the building. We could see they were managing the space as well as they could in the circumstances. However, this layout did not offer an environment which reduced accidents. Using the patient area for storage also increased the likelihood of impeding patients and staff escaping in the event a fire occurred.

On Ward 5 at Moseley Hall Hospital there was adequate storage room and we saw that equipment was appropriately stored to avoid being a safety hazard.

The environments had risk assessments to highlight where risks were and how those risks would be managed to keep patients safe. For example, on neuro rehabilitation unit at Moseley Hall Hospital they had ligature free rooms to use for at risk patients. In addition, those patients identified as being a high risk of using a ligature would be appropriately risk assessed, observed and managed.

On ward 5 there was a secure airlock area to ensure the safety of patients who were subject to a Deprivation of Liberty Safeguards could not leave unless assessed as suitable to do so. For those patients free to move without restriction there were clear signage that they were free to leave and staff on reception were aware of the principles. This meant patient safety was considered and systems were in place to keep them safe.

Each ward had equipment available to them to enable them to respond to patient needs. Equipment was maintained and managed using an estates and facilities service. Equipment was checked and we saw stickers and checklists documenting that they were safe to use. On the stroke unit at Moseley Hall Hospital the resuscitation trolley was not locked. It was checked twice a day; however, checking would not have prevented people from accessing it without permission.
Patients with complex health issues had the right equipment to support them with their additional needs. For example, a patient who required specialist equipment to aid them to independently go to the bathroom was provided with the equipment they required.

The trust ensured all staff within inpatient areas received theoretical and practical training on the use of standardised evacuation equipment. As of 31 July 2018, overall compliance with this training for adult inpatient areas was 87% against a trust target of 85%. Site specific training was also provided at Moseley Hall Hospital, West Heath Hospital, Perry Trees Centre, Anne Marie Howes and CU27, Good Hope. The trust confirmed that patients who had been identified as vulnerable due to their reduced mobility would have a personal emergency evacuation plan and in some cases, this was incorporated into their care plan.

The trust followed a three-tiered physical approach to control access to Control of Substances Hazardous to Health (COSHH) products. This included digi-lock or access control restricting general access to inpatient wards, access control for domestic areas and COSHH products situated in lockable cabinets. Each ward or department were responsible for carrying out risk assessments and compliance to trust policies was monitored by the Health and Safety Manager by carrying out unannounced visits.

Assessing and responding to patient risk

The leadership team ensured that nursing staff had the right skills. This meant they had the right level of competency which was based on the complexity of the patient’s needs to ensure the safest patient care. For example, a dementia lead nurse who had introduced a number of changes to the way staff worked with patients to help manage difficult behaviours, challenges related to care and improve outcomes overall.

The trust had a standard operating procedure that outlined the responsibilities of staff at all levels to provide a clear pathway of care. It outlined the process by which levels of observation were assessed, recorded and reviewed. The standard operating procedure included a process for identifying when extra staffing may be required which was linked to safe staffing for wards. The purpose of the standard operating procedure was to provide a framework for observation, including heightened levels of observation to reduce patient harm.

Patients clinical observations were recorded and monitored dependent on individual levels of care. Staff talked to us about the use of National Early Warning System (NEWS), a tool for nurses to help monitor their patients and respond to a patient experiencing a sudden decline. Staff followed national guidance and assessed and documented patient risk on admission and 24 hours later using evidence based tools. This included nutritional risk assessments, pressure ulcer and falls risk tools. All patient records we looked at were completed, appropriately reviewed at regular intervals and escalated if a trigger had been met. This meant that it was a meaningful tool to help staff identify when further help was needed to keep patients safe and well.

A policy was in place for the recognition and management of deteriorating patient (adults). Within this policy, there was a flowchart for the pathway to transfer a deteriorating patient to an acute hospital. The trust confirmed that an incident form would be completed for any unplanned transfers to the acute setting. The flowchart referred to a policy for the safe transfer and clinical handover of care of patients and service users.

The trust had a statutory obligation to patients to ensure compliance to National Institute for Health and Care Excellence (NICE) guidelines in relation to Venous Thromboembolism (VTE) risk assessment. This had been identified as a critical patient safety measure. The trust carried out a re-audit of the VTE (venous Thrombosis) policy between 24 July and 28 July 2017. It aimed to assess if all the VTE guidelines had been adhered to for all patients during their stay in intermediate care, Moseley Hall Hospital (MHH) and West Heath Hospital (WHH). This included the identification and management of VTE risk in accordance with the trust guidelines.
The audit showed areas of good practice such as all patients audited had a VTE risk assessment completed within 24 hours by the nurses. Perry Trees Centre was the only area that consistently reviewed the patients weekly. This was done by different GP’s that attended the unit and fed back to the managers. Willow had started weekly reviews of the patients, which was documented by the pharmacist on the ward round and not a doctor. CU27 were consistent with dating and timing when the initial assessments were carried out.

Areas that required improvement included MHH, WHH community unit 27 and Anne Marie Howes unit as reviews by the medical team were not consistent. There was also a lack of written information (leaflets) for patients, carers and relatives. This was clearly documented on the VTE risk assessment form. MHH were not consistent due to medical cover, it was noted one doctor always reviewed the patients depending on which ward he was covering and at Willow House – a pharmacist documented on the risk assessment when the patient was reviewed, this was mainly during the MDT.

Recommendations following the audit included, Perry Trees Centre to share incident information and best practice at clinical effectiveness meetings and doctor forums. All qualified nurses to do initial assessment within urgent care for consistency. Doctors were to continue to review patients VTE risk assessment on a weekly basis, unless the patient’s condition changed. There also needed to be clear documentation in the patient’s medical notes by the medics or advanced nurse practitioners why patients were not on prophylaxis. All clinical team leaders and band 6 nurses needed to ensure that VTE risk assessments were reviewed on ward round/MDT or when the patient’s condition changed. Clinical development nurse/matrons were required to ensure there were enough leaflets within the bedded areas and re-audit in six months’ time.

During 2016/17, an overall compliance rate of 100% per cent was achieved for patients who received a risk assessment for venous thromboembolism. Throughout 2016/17 the trust exceeded the target of 95% and continued to achieve above the national average of 95.64% (Quarter 3). The trust achieved full compliance between 2014 and 2017 with its VTE prevention program which was in place to reduce the number of deaths caused by blood clots acquired in hospital.

We observed a nurse handover at the enhanced assessment bed service (ward 27) at Good Hope Hospital. It was attended by all staff on shift and took place twice daily at the beginning and end of each shift in a private and quiet setting. Staff were provided with an up to date list of patients. Their status and plan of care were discussed to ensure staff had the information they needed to promote rehabilitation and wellbeing and manage the patient safely while on the ward.

We looked at 14 sets of patient’s records to review risk assessments and care plans and saw that they were person centred, highlighted associated risks and there were management plans to address the risks. For example, patients with delirium were assessed as to whether they needed sensor mats. Staff carried out lying and standing blood pressures to reduce patient falls. Medics on the wards took the lead for this. We saw posters displayed and there were updates for staff to see how well they were doing.

Falls had been identified as an area of concern across the wards we inspected. We reviewed the trust’s reported data on falls and saw a reduction in patient falls. Measures were introduced to reduce the number of falls. On ward 5 at Moseley Hall Hospital there had been many falls over the winter period. This number had been significantly reduced by introducing improvement measures. For example, the ward increased the number of health care assistants to provide one to one care with patients who needed it. Staff received a two-week fall focussed professional development input. This meant that staff had the opportunity to improve their knowledge and understanding of falls prevention to reduce the incidence of falls. Staff focussed on better recording of assisted falls and developed a system of monitoring. Information relating to the incidence of falls was recorded on a falls board to share information with staff.
Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Senior staff representatives and staff from bank and bed management attended a morning telephone call Monday to Friday to ensure appropriate staffing in terms of skills mix and numbers for each ward to keep people safe. Staff told us that in high pressure times they extended these calls to weekends. We observed these meetings and found them to be comprehensive and focussed on keeping patients and staff safe.

Managers could access a bank of temporary staff and approached the same staff for continuity. Agency staff were used as a last resort with approval of managers. Each matron told us that they had seen improvements in staffing in the past 12 months because of recruitment. Senior staff were permitted to use agency staff outside approved agencies, however this required director level approval and was reportable to NHS Improvement. This helped to control and reduce agency staff costs.

All staff had access to a health rostering system application which meant staff had direct access to the system to book themselves on to bank shifts that suited their own circumstances. This meant there was flexibility and more shifts were filled. We looked at staffing records and saw that on average bank staff covered seven or eight shifts a month. For example, at West Heath, Willows ward were fully established with rare shifts outstanding. Ward 9 at Moseley Hall Hospital had one shift in one week that was outstanding. We looked at ward five at Moseley Hall Hospital over a four-week period from 3 April 2018 and saw just one early shift outstanding. This increased in winter months.

Safer Staffing levels

Staff fill rates compare the proportion of planned hours worked by staff (Nursing, Midwifery and Care Staff) to actual hours worked by staff (day and night). Community trusts were required to submit a monthly safer staffing report to the Quality Governance and Safety Committee (QGSC) and NHS Improvement and undertake a six-monthly safe staffing review by the director of nursing. This was to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for nursing staff during the day means; in January 70% of the planned working hours for daytime nursing staff were actually ‘filled’.

The below table covers staff fill rates for registered nurses and care staff during September 2017, October 2017 and January 2018. The trust did not provide data for the winter pressure months.

For community inpatient services, there is information for three locations. These are:

- Ann Marie Howes
- Perry Trees Centre
- Community Unit 27

The following tables consider safe staffing at these sites.

### Ann Marie Howes

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required shifts</td>
<td>Filled shifts</td>
</tr>
<tr>
<td>January 2018</td>
<td>3,906</td>
<td>123.2%</td>
</tr>
<tr>
<td>October 2017</td>
<td>5,580</td>
<td>83.4%</td>
</tr>
<tr>
<td>September 2017</td>
<td>5,400</td>
<td>80.1%</td>
</tr>
</tbody>
</table>
### Perry Trees Centre

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required shifts</td>
<td>Filled shifts</td>
</tr>
<tr>
<td>January 2018</td>
<td>3,906</td>
<td>109.8%</td>
</tr>
<tr>
<td>October 2017</td>
<td>5,580</td>
<td>77.3%</td>
</tr>
<tr>
<td>September 2017</td>
<td>5,400</td>
<td>84.1%</td>
</tr>
</tbody>
</table>

### Community Unit 27

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required shifts</td>
<td>Filled shifts</td>
</tr>
<tr>
<td>January 2018</td>
<td>3,317</td>
<td>86%</td>
</tr>
<tr>
<td>October 2017</td>
<td>3,317</td>
<td>116%</td>
</tr>
<tr>
<td>September 2017</td>
<td>3,210</td>
<td>116.4%</td>
</tr>
</tbody>
</table>

**Key**

- **> 125%**
- **< 90%**

*(Source: Safer Staffing Data – Trust website)*

At all three sites, there were issues filling day shifts in at least one month. However, in both September and October 2017, the Perry Trees Centre and Ann Marie Howes centre failed to fill at least 90% of the required day shifts. This meant the optimal level and mix of nursing staff required to deliver quality care was not always achieved.

The trust informed us that if they did not meet the required fill rate of 90%, the division would reallocate staff with the appropriate skills and competencies who were not undertaking direct patient contact.

### Staffing

The trust provided data for trust wide staffing levels and only broke the figures down to service level for three inpatient sites (Ann Marie Howes, Perry Trees and community unit (CU27), Good Hope Hospital). As a result, we are unable to discuss staffing levels for all of the community inpatient services we inspected.

*(Source: Routine Provider Information Request (RPIR) P16 – Total numbers – Planned vs actual)*

### Vacancies

From January 2017 to December 2017, the trust reported an overall vacancy rate of 23% in community inpatient services, compared to an overall trust target of 9%. This was due to nursing staff shortages in England. There had been an ongoing recruitment campaign and staff told us they had started to see a slow trickle of new starters. Wards used bank and more rarely agency staff to fill any gaps. We saw no impact on patient care. This was because bank and agency staff were used to ensure safe staffing levels. There were plans in place for ongoing recruitment across all inpatient wards.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total % vacancies overall (excluding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Total % vacancies overall (excluding seconded staff)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>33%</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>30%</td>
</tr>
<tr>
<td>Other (including admin &amp; clerical)</td>
<td>10%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>4%</td>
</tr>
<tr>
<td>Location total</td>
<td>29%</td>
</tr>
</tbody>
</table>

**Ann Marie Howes Centre**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>17%</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>5%</td>
</tr>
<tr>
<td>Other (including admin &amp; clerical)</td>
<td>-115%*</td>
</tr>
<tr>
<td>Location total</td>
<td>8%</td>
</tr>
</tbody>
</table>

*Negative numbers indicate a staffing surplus

**Perry Tree Centre**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>21%</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>8%</td>
</tr>
<tr>
<td>Other (including admin &amp; clerical)</td>
<td>-219%*</td>
</tr>
<tr>
<td>Location total</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Community Unit 27**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Total number of substantive staff</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Other (including admin &amp; clerical)</td>
<td>12</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>107</td>
</tr>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>118</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>3</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>6</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td><strong>245</strong></td>
</tr>
</tbody>
</table>

All staff who were leaving the trust were sent an email with a link to an online questionnaire, staff were also able to request a face-to-face exit interview. Information from the questionnaires was collated anonymously to identify reasons for leaving. However, this information was not available at staff group level to be able to identify any trends or if there were specific locations that had a high turnover.

The following tables show the turnover per site. Only the staff groups with turnover have been included in the table, however the total number of substantive staff at the location is for all staff groups.
### Moseley Hall

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care assistants</td>
<td>35.2</td>
<td>2.6</td>
<td>7.3%</td>
</tr>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>42.2</td>
<td>0.6</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Total (for the location)</strong></td>
<td><strong>89.8</strong></td>
<td><strong>3.2</strong></td>
<td><strong>4.1%</strong></td>
</tr>
</tbody>
</table>

### Ann Marie Howes Centre

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care assistants</td>
<td>26.4</td>
<td>4.6</td>
<td>17.5%</td>
</tr>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>15.4</td>
<td>1.0</td>
<td>6.5%</td>
</tr>
<tr>
<td><strong>Total (for the location)</strong></td>
<td><strong>43.1</strong></td>
<td><strong>5.6</strong></td>
<td><strong>13.4%</strong></td>
</tr>
</tbody>
</table>

### Perry Trees Centre

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (including admin &amp; clerical)</td>
<td>1.3</td>
<td>1.7</td>
<td>130.4%</td>
</tr>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>13.8</td>
<td>2.0</td>
<td>14.5%</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>26.3</td>
<td>2.0</td>
<td>7.6%</td>
</tr>
<tr>
<td><strong>Total (for the location)</strong></td>
<td><strong>41.4</strong></td>
<td><strong>5.7</strong></td>
<td><strong>13.7%</strong></td>
</tr>
</tbody>
</table>
Community Unit 27

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care assistants</td>
<td>18.9</td>
<td>0.6</td>
<td>3.2%</td>
</tr>
<tr>
<td><strong>Total (for the location)</strong></td>
<td><strong>35.3</strong></td>
<td><strong>0.6</strong></td>
<td><strong>3.2%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

We asked the trust what the service was doing to support trust exploration of high turnover rates across the service. Although the trust is below their target for overall turnover, there were pockets that were above the trust target. For example, the turnover rate for healthcare assistants at Anne Marie Howes Centre was 17.5%. Although the actual staff numbers of turnover are low, Perry Trees Centre also had a high turnover rate for nursing staff and other (admin and clerical).

The staff group, other (including admin and clerical) had the highest overall percentage of staff levers in the last 12 months and was the only group overall which exceeded the trust target. However, this may have reflected the fact there was a staff surplus for this group. For example, at Perry Trees Centre there was a vacancy rate of –219%.

Sickness

From January 2017 to December 2017 the trust reported an overall sickness rate of 7.5% in community inpatient services. The trust did not have an overall sickness target, but instead had a monthly target which recognises seasonal trends. Therefore, we are unable comment on comparative sickness performance for staff in community inpatient services.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>4770.9</td>
<td>439.5</td>
<td>9.2%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>4263.5</td>
<td>279.4</td>
<td>6.6%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>238.9</td>
<td>12.0</td>
<td>5.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>169.3</td>
<td>7.0</td>
<td>4.1%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>78.1</td>
<td>0.3</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td><strong>9520.7</strong></td>
<td><strong>738.2</strong></td>
<td><strong>7.8%</strong></td>
</tr>
</tbody>
</table>

Moseley Hall

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total available permanent staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>1,271.2</td>
<td>121.0</td>
<td>9.5%</td>
</tr>
<tr>
<td>Staff group</td>
<td>Total available permanent staff days</td>
<td>Total permanent staff sickness days</td>
<td>Total % permanent staff sickness overall</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>1,579.5</td>
<td>110.4</td>
<td>7.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>169.3</td>
<td>7.0</td>
<td>4.1%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>134.5</td>
<td>2.0</td>
<td>1.5%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>78.1</td>
<td>0.3</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,232.7</strong></td>
<td><strong>240.8</strong></td>
<td><strong>7.4%</strong></td>
</tr>
</tbody>
</table>

### Ann Marie Howes Centre

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total available permanent staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>40.6</td>
<td>4.3</td>
<td>10.7%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>803.3</td>
<td>64.8</td>
<td>8.1%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>467.1</td>
<td>28.6</td>
<td>6.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,311.0</strong></td>
<td><strong>97.7</strong></td>
<td><strong>7.5%</strong></td>
</tr>
</tbody>
</table>

### Perry Trees Centre

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total available permanent staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>22.5</td>
<td>5.7</td>
<td>25.4%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>800.4</td>
<td>52.3</td>
<td>6.5%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>419.7</td>
<td>19.9</td>
<td>4.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,242.6</strong></td>
<td><strong>78.0</strong></td>
<td><strong>6.3%</strong></td>
</tr>
</tbody>
</table>

### Community Unit 27

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total available permanent staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>574.1</td>
<td>76.1</td>
<td>13.2%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>471.5</td>
<td>26.0</td>
<td>5.5%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>3.9</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,049.4</strong></td>
<td><strong>102.1</strong></td>
<td><strong>9.7%</strong></td>
</tr>
</tbody>
</table>

### West Heath Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total available</th>
<th>Total permanent staff</th>
<th>Total % permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>permanent staff days</td>
<td>sickness days</td>
<td>staff sickness overall</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------</td>
<td>---------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>1,321.9</td>
<td>125.3</td>
<td>9.5%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting</td>
<td>1,325.7</td>
<td>94.4</td>
<td>7.1%</td>
</tr>
<tr>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>37.5</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>2,685.0</td>
<td>219.7</td>
<td>8.2%</td>
</tr>
</tbody>
</table>
Sickness absence was monitored and discussed at a bi-monthly workforce and organisational development meeting. We noted the reports submitted noted the sickness rate for the division against the trajectory. However, this information was not split down to staff group level or site specific to ascertain if there were any trends. The division had put an action plan into place which identified objectives to reduce short-term sickness, reduce winter absence, support to managers, reduce stress related absence and musculoskeletal (MSK) related absence. The division had identified that stress and MSK related absences were high as this was featured in their monthly human resource staffing sickness report, although it was noted that this did not provide an analysis related to any particular locations.

**Nursing – Bank and Agency Qualified nurses**
As at December 2017, the trust reported an overall bank and agency usage rate of 97.3% for qualified nursing staff.

<table>
<thead>
<tr>
<th>Total Number of Shifts available</th>
<th>Total Shifts Filled by Bank Staff</th>
<th>% Usage of Bank Staff</th>
<th>Total Shifts Filled by Agency Staff</th>
<th>% Usage Agency Staff</th>
<th>Total shifts NOT filled by Bank Staff</th>
<th>Total shifts NOT filled by Agency Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,592</td>
<td>4,139</td>
<td>54.5%</td>
<td>4,257</td>
<td>56.6%</td>
<td>358</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

The trust’s data showed the total of shifts filled exceeded the total number of shifts available during the period.

(Source: Routine Provider Information Request (RPIR) P20)

We explored the above data with the trust. The trust told us that the 97.3% quoted related to the fulfilment rate against the requested bank and agency shifts.

The trust undertook routine analysis of the inpatient nursing workforce in the safer staffing reports that were visible to quality governance and safety committee (QGSC). The analysis looked into the substantive to non-substantive (for example, bank and agency) ratio to advise NHS Improvement accordingly on a quarterly basis. The period used for the analysis included within the return was the financial year 2017/18.

The trust utilised a roster system for managing inpatient nursing shifts (managed in hours) and the analysis showed that of the hours worked in inpatient wards during the period April 2017 to March 2018, on average 63% were filled by substantive employees. Of the remaining 37%, 23% was delivered by bank employees and 14% was filled by agency staff.

While a distinction was made between substantive and bank employees almost half of the trust’s bank employees also had a substantive assignment with the trust. In April 2017, 41% of the bank hours were supplied by employees that had a substantive assignment. Twenty-six percent of the bank hours were supplied by employees that had a substantive assignment on the very ward where they worked the bank shift. This assisted in maintaining consistency of safety, quality, care and processes as well as helping the trust meet its target reduction in agency usage. This was reported in the safer staffing report.

The high percentage figures represented within the provider information request submitted, based upon the trusts’ investigation, related to fulfilment percentages achieved of all requests received for bank or agency employees. For example, for the month of April 2017, around 36% of hours
delivered were done so by either bank or agency, this constituted around 97% of all bank and agency requests received, not of all the hours (shifts) worked.

The below table shows the analysis by Ward and the graph shows the position in month for all inpatient wards. Ward 9 were the highest user of agency, however, Ward 9 block booked agency in advance allowing for consistency of staff and maintenance of safety, quality, care and process due to nature of this client group.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Agency</th>
<th>Bank</th>
<th>Substantive</th>
<th>Grand Total</th>
<th>Agency %</th>
<th>Bank %</th>
<th>Substantive %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Marie Howes Care Centre</td>
<td>7,288.58</td>
<td>13,273.67</td>
<td>56,333.90</td>
<td>76,896.15</td>
<td>9.50%</td>
<td>17.30%</td>
<td>73.30%</td>
</tr>
<tr>
<td>Community Unit 27</td>
<td>5,097.03</td>
<td>17,752.90</td>
<td>44,519.85</td>
<td>67,369.78</td>
<td>7.60%</td>
<td>26.40%</td>
<td>66.10%</td>
</tr>
<tr>
<td>MHH CCDU</td>
<td>5,485.27</td>
<td>7,670.20</td>
<td>27,682.73</td>
<td>40,838.20</td>
<td>13.40%</td>
<td>18.80%</td>
<td>68.10%</td>
</tr>
<tr>
<td>MHH Ward 5</td>
<td>9,594.33</td>
<td>13,440.05</td>
<td>49,080.63</td>
<td>72,115.02</td>
<td>13.30%</td>
<td>18.60%</td>
<td>68.10%</td>
</tr>
<tr>
<td>Perry Trees Care Centre</td>
<td>17,019.02</td>
<td>17,451.47</td>
<td>53,878.42</td>
<td>88,348.90</td>
<td>19.30%</td>
<td>19.80%</td>
<td>61.00%</td>
</tr>
<tr>
<td>Rehab Ward 9</td>
<td>21,269.23</td>
<td>25,082.82</td>
<td>55,448.82</td>
<td>101,800.87</td>
<td>20.90%</td>
<td>24.60%</td>
<td>54.50%</td>
</tr>
<tr>
<td>Sheldon Unit</td>
<td>7,726.77</td>
<td>17,725.20</td>
<td>45,004.15</td>
<td>70,456.12</td>
<td>11.00%</td>
<td>25.20%</td>
<td>63.90%</td>
</tr>
<tr>
<td>Ward 06 MHH</td>
<td>13,084.03</td>
<td>16,254.32</td>
<td>40,467.67</td>
<td>70,806.02</td>
<td>18.70%</td>
<td>23.30%</td>
<td>58.00%</td>
</tr>
<tr>
<td>Ward 08 MHH</td>
<td>9,635.88</td>
<td>23,329.40</td>
<td>41,448.83</td>
<td>74,414.12</td>
<td>12.90%</td>
<td>31.40%</td>
<td>55.70%</td>
</tr>
<tr>
<td>WHH Ward 12</td>
<td>7,038.03</td>
<td>17,022.08</td>
<td>35,116.38</td>
<td>59,176.50</td>
<td>11.90%</td>
<td>28.80%</td>
<td>59.30%</td>
</tr>
<tr>
<td>Willow House</td>
<td>3,941.65</td>
<td>10,995.47</td>
<td>37,037.88</td>
<td>51,975.00</td>
<td>7.60%</td>
<td>21.20%</td>
<td>71.30%</td>
</tr>
<tr>
<td><strong>2017/18 Total</strong></td>
<td><strong>108,397.67</strong></td>
<td><strong>181,891.82</strong></td>
<td><strong>495,677.52</strong></td>
<td><strong>785,967.00</strong></td>
<td><strong>13.80%</strong></td>
<td><strong>23.10%</strong></td>
<td><strong>63.10%</strong></td>
</tr>
</tbody>
</table>

(Source: Additional data request from trust - DR165)

**Medical locums**

The trust identified that there was a risk that the quality of patient care could be compromised due to the high use of locum medical staff in September 2017. This was identified on the trust risk register and there were plans to develop associate physician roles and advanced clinical practitioners in the long term to ensure adequate competency on the wards always. The trusts plan with regards to advanced clinical practitioners was well underway. However, the trust had
decided to postpone the role of associate physician, which remained under review as the Birmingham and Solihull Sustainability and Transformation Partnership (STP) work programmes developed in line with the emergence of new models of care.

From January 2017 to December 2017, 357 (100%) shifts were filled by agency staff across the entire core service. This meant there may have been a risk to patient safety. For example, locums had to adapt to the trust’s own nuances, such as differences in ordering investigations, drug charts, bleeping, and different protocols for managing patients.

(Source: Routine Provider Information Request (RPIR) P21 Medical agency locum)

We explored the above data with the trust who informed us the data was factually incorrect.

The 100% quoted relates to the fulfilment rate (i.e. fill rate) against the requested bank and agency shifts for locums.

As part of the medical workforce model changes through 2017 to 2019, combined with recruitment difficulties and to ensure consistency of care, the trust utilised longer term medical locums as the medical model changed towards a blended Multi-Disciplinary Team that included Advanced Nurse Practitioners.

Junior Grade Medical Staffing
The trust informed us they had been previously impacted negatively by gaps within the Health Education England rotational programme which had increased the need for temporary medical staffing. In addition, trainee junior medical staff had been removed from the West Heath Hospital site. The trust had developed a new model involving ANPs which was being implemented. One ANP had commenced in post and had replaced a locum junior doctor and two further posts had been recruited to and were due to commence in September 2018.

The trust had put mitigation in place by ensuring that long term bookings were in place and wherever possible staff were linked to senior medical staff and a consistent clinical area to ensure continuity of care. The percentage related to around seven WTE staff across all the bedded areas.

<table>
<thead>
<tr>
<th></th>
<th>Average Q4 17/18</th>
<th>Average Q4 17/18</th>
<th>Average Q1 18/19</th>
<th>Average Q1 18/19</th>
<th>Average Q2 18/19</th>
<th>Average Q2 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Grade</td>
<td>17.38%</td>
<td>Agency</td>
<td>19.78%</td>
<td>Agency</td>
<td>19.74%</td>
<td>Agency</td>
</tr>
<tr>
<td>Consultant / H.</td>
<td>19.78%</td>
<td>Agency</td>
<td>59.57%</td>
<td>Agency</td>
<td>50.49%</td>
<td>Agency</td>
</tr>
<tr>
<td>(Source: Additional data request from trust - DR165)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In addition, locum staff were also entitled to attend internal trust training at no charge on the condition that it did not negatively impact on patient care. This provided assurance to the trust over staff competencies and provided an element of integration into the team. Long term locum staff were also offered pastoral support and guidance by the divisional clinical director.

Consultant cover
The trust was unable to provide the appropriate data at core service level.

(Source: Routine Provider Information Request (RPIR) – P22 Consultant cover)
Consultant / Higher Grade
The trust utilised one whole time equivalent consultant/higher grade as a medical locum. This was a long term booking to ensure continuity of care and ensured that the post holder was aware of trust policies and procedures. This locum doctor equated to around 20% of the consultant/higher grade workforce. Previous attempts to recruit substantively and as a NHS locum had failed, with the most recent in June 2018 attempt receiving no applications. A revised job description had been sent to the Royal College of Physicians for review and the trust was awaiting a response to the job description to stabilise the workforce.

Suspensions and supervisions
During the reporting period from January 2017 to December 2017, the core services reported that there were no cases where staff have been either suspended, placed under supervision or had restricted practice.
(Source: Routine Provider Information Request (RPIR) – P23 Suspensions or supervised)
Quality of records

Staff kept appropriate records of patients’ care and treatment. Records overall, were clear, up-to-date and available to all staff providing care.

The trust had a paper care record system. Each patient’s care record was stored securely on the wards. In some cases, for example at the enhanced assessment bed service at Good Hope Hospital each patient had three separate records. We asked staff how they shared information from the records with staff in the community and they told us they used a secure fax system. This meant they were reliant on older methods of technology that may not be as efficient as more up to date technological advances.

We looked at 14 patient care records. The quality was mostly of a high standard. On the enhanced assessment bed service (Ward 27) at Good Hope Hospital the evidence based risk assessment tools and care plans clearly highlighted risks and how they were to be managed specific to that patient’s needs. We saw evidence of consent, which was reviewed regularly, family involvement and where appropriate the involvement of patients and other professionals.

However, at West Heath Hospital the care records on one ward were not always completed to a high standard. We looked at care plans and risk management plans. Whilst we were confident patients were receiving person centred care, we found patient care plans were generic and not person centred. This was not in line with NHS England recommendation that staff should offer everyone with a long-term condition a personalised care plan. A person-centred care plan ensures that that people's preferences, needs and values guide clinical decisions, and provides care that is respectful of and responsive to them.

All patient care notes were regularly audited for content and quality to ensure standards were met and help make improvements. When concerns were identified, the learning was shared and areas for improvements were actioned. The results from the care records audits were shared in various formats, for example, on quality boards where everyone on the ward could access them and in the form of reports.

Medicines

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

We spoke with pharmacists and pharmacy technicians about how they ensured the proper and safe use of medicines. Each site has its own dispensary for the provision of medicines including monitored dosage systems.

Staff could access pharmacy seven days a week and there were out of hours services available if needed. A pharmacy technician ensured that all the patients’ medicines were available for discharge.

Medicines, including controlled drugs, were stored securely, at suitable temperatures to maintain their quality. Therefore, appropriate arrangements were in place to ensure these were maintained. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines were called controlled medicines or controlled drugs.

Sixteen out of 24 inpatient doctors (67%) had completed medicines management training. The trust told us the divisional leadership team had a plan in place to ensure all eight doctors who had not completed the training would do so by 30 September 2018. Mitigation was provided by nursing staff who were at a 92% compliance rate; the remaining 8% were due to complete the training by 30 September 2018.

During 2016 and 2017, most incidents in the medication, medical gases, medication delivery system incidents category, trust wide, related to issues at the point that medication is / should be
administered. Many of the incidents recorded report that medication had not been administered at the time it was due. Data specific to each site was not available.

All medication incidents were monitored through the medicines management team and reported to the clinical governance committee. Where necessary, advice was given and direct intervention was undertaken. The trust reported that most of the medication incidents did not result in patient harm and were generally of low risk.

Staff were involved in medicines audits and learning was shared at clinical effectiveness meetings. Medication incidents were reviewed every month. Significant incidents were to be reviewed in detail and learning disseminated across all wards. Various initiatives had been implemented, for example on one ward there were many missed controlled drugs and changing the time of administration had reduced this. Missed doses had been taken up as a patient safety ambassador project. Wards were trialling double checking medicines charts at the end of a drug round. All missed doses were reported on the trust incident reporting system and their re-audits were scheduled to measure the success of changes.

Safety performance

The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.

Data collection took place one day each month, a suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of the suggested data collection date. Staff could access information relating to the safety thermometer on the trust intranet which outlined how well the trust were doing in reducing harm. For example, improvements were seen in results measured using the safety thermometer to further reduce the incidence of falls from harm and to sustain the results. This information was displayed on notice boards in corridors for all people to see.
New Pressure Ulcers

The trust saw a spike in the prevalence for new pressure ulcers in July 2017 for community inpatient services with a rate of 0.64. Overall, the rate fluctuates between zero and 0.64 throughout the reporting period of February 2017 to February 2018.

Prevalence rate (number of patients per 100 surveyed) of new pressure ulcers at Birmingham Community Healthcare NHS Foundation Trust

Staff at the trust followed the SSKIN model. SSKIN was a five-step model for pressure ulcer prevention:

- **Surface**: make sure your patients have the right support
- **Skin inspection**: early inspection means early detection. Show patients & carers what to look for
- **Keep your patients moving**
- **Incontinence/moisture**: your patients need to be clean and dry
- **Nutrition/hydration**: help patients have the right diet and plenty of fluids

SSKIN was embedded into the pressure ulcer pathway, developed by NHS Midlands and East, and its prevention and treatment bundles.

Staff then applied SSKIN in the new Pressure Ulcer Path which was developed by the Strategic Health Authority to guide them step by step through the process of screening, assessing, preventing and treating pressure ulcers.

These two tools kicked off a major campaign to motivate staff to prevent and treat pressure ulcers, it included tools to help staff communicate clearly with patients and carers.
**New Catheter & UTIs**

From February 2017 to February 2018, the prevalence rate of catheter urinary tract infections followed an upward trend in community inpatients services at Birmingham Community Healthcare NHS Foundation Trust. There was a peak in August 2017 with a rate of 0.8.

**Prevalence rate (number of patients per 100 surveyed) of new CUTIs at Birmingham Community Healthcare NHS Foundation Trust**

(Figure showing prevalence rate from February 2017 to February 2018 with a peak in August 2017)

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**Falls with Harm**

From February 2017 to February 2018, the prevalence rate of falls within community inpatient services at the trust fluctuated between zero and 1.3.

**Prevalence rate (number of patients per 100 surveyed) of falls with harm at Birmingham Community Healthcare NHS Foundation Trust**

(Figure showing prevalence rate from February 2017 to February 2018 with fluctuations)

(Source: NHS Safety Thermometer)

Measures had been introduced to reduce the number of falls. For example, ward five at Moseley Hall Hospital increased the number of health care assistants to provide one to one care with
patients who needed it and staff received a two-week fall focussed professional development input. This may have accounted for the reduction on the number of falls.

Incident reporting, learning and improvement

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.

During the period 1 April 2016 and 31 March 2017, a total of 7,044 incidents were reported trust wide. This figure included 99 Serious Incidents (SIs), of which 21 were subsequently reclassified as not being SIs, leaving an overall total of 78. Of these 78 serious incidents, 54 related to the development of pressure ulcers and 15 to in-patient fractures. This was in line with what staff told us.

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses, and to report them internally and externally, where appropriate. They recorded incidents using a recognised electronic system. This meant that there was a standard of information required which was shared with managers for review and next steps. Incidents would then either be investigated or signed off as complete. Relevant staff, services, partner organisations and people who used services were involved in reviews and investigations. There was evidence of investigation followed by action planning and duty of candour followed to keep patients and those involved in their care informed with how incidents are managed. This meant there were good systems and processes in place to ensure incidents were reviewed and investigated safely.

We saw examples of learning and improving following many themes relating to incidents. For example, a programme to reduce falls which was highlighted as the most common type of incident resulting in serious harm. Urgent care inpatient service had 20 falls resulting in fracture during 2017/18. On the enhanced assessments bed service unit (ward 27) at Good Hope Hospital, there were no falls in over 30 days compared to five falls in December 2017 because of the measures taken from the programme of work. We looked at three root cause analysis relating to two patient incidents of pressure ulcers and one patient incident where there was a fall. We found that the documentation did not demonstrate a robust approach to investigating, learning or making appropriate changes following the incidents. However, we did see that the management of falls and pressure ulcers in practice was robust and there was evidence of changes in practice. These were ongoing pieces of work to ensure the changes were sustained and improvements continued.

Handovers had been updated to reflect falls and patients at risk of falling and care plans were personalised to reflect input from patients and their families in how best to manage their risk of falls. This meant that lessons were being learned and changes introduced to keep patients safe as a result.

Serious Incidents - STEIS

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incidents (SIs) in community inpatients services, which met the reporting criteria, set by NHS England between, February 2017 and January 2018. Of these, the most common type of incident reported was Slips/trips/falls (63% of total incidents).
Serious Incidents (SIRI) – Trust data
From January 2017 to December 2018, trust staff in this core service reported 27 serious incidents.

Of these, none involved the unexpected death of a patient.

The number of the most severe incidents recorded by the trust incident reporting system is not comparable with that reported to Strategic Executive Information System (STEIS). This gave us less confidence in the validity of the data.

Prevention of Future Death Reports
The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths report which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no prevention of future death reports sent to Birmingham Community Health NHS Foundation Trust relating to the community inpatients service.

Source: Routine Provider Information Request (RPIR) – P86 – Prevention of future death reports
Is the service effective?

At our last inspection of 2014 we rated these services as ‘Requires Improvement’. At this inspection our rating improved to ‘Good’.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

People's physical, mental health and social needs were holistically assessed. This was indicated in patient care records, risk assessments and care plans. Their care, treatment and support was delivered in line with legislation, standards and evidence-based guidance from National Institute for Care and Health Excellence (NICE) and other expert professional bodies, to achieve effective outcomes.

There were lots of examples where staff used best practice guidelines, for example, the neuro and stroke rehabilitation units, spasticity was a common symptom seen in many neurological conditions, notably head injury, spinal cord injury, stroke, cerebral palsy, and multiple sclerosis. Staff used best practice guidelines for spasticity management and tracker. Standards for the care of adult patients with a temporary tracheostomy was followed and staff were appropriately trained and supervised to manage these conditions. This was in line with guidance such as Standards for the care of adult patients with a temporary tracheostomy; Standards and guidelines Tracheostomy care Intensive Care Society Standards, NICE guidelines, quality standards and other good-practice guidance was followed, for example dementia, prevention and management of pressure ulcers, urinary incontinence in neurological disease and stroke rehabilitation. The trust employed specialists for patients assessed with these needs. For example, they employed a lead dementia nurse who supported staff in keeping up to date with what the most up to date guidance was and by training staff on how to best support patients living with dementia and promote independence. The dementia lead nurse provided us with numerous examples of where they had introduced best practice which resulted in positive changes for the patients. Staff gained valid consent from people with dementia and we saw staff checking that the patients understood what they had been asked.

There were gyms with a wide range of appropriate equipment to aid rehabilitation at the neuro rehabilitation and stroke rehabilitation wards. We saw lots of patients accessing occupational therapy and the equipment they used to promote independence and to aid their rehabilitation. This was in line with guidance such as Rehabilitation Commissioning Guidance – April 2016

Those patients with long-term conditions, complex needs or who received rehabilitation had clear personalised care plans in their care records which were up to date and in line with relevant good-practice guidance which set out clear outcome goals. Staff identified concerns by regularly reviewing patient needs and made timely referrals to other professionals where necessary.

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 adjusted for patients’ religious, cultural and other preferences.

Patient meal times were protected. This meant there were no interruptions during this time. Patients were encouraged to eat their meals in the dining rooms if they could and relatives were encouraged to visit during this time to offer help if needed. Patients were also encouraged to bring their own food if they wanted to. Hot and cold drinks were available throughout the day and night and water jugs were refreshed regularly. There were kitchens available for patients to make their own food as part of their recovery. Patients told us that the quality of food was good and there
was a choice of meals. Perry Trees Centre had a canteen downstairs where patients could eat also and they would adapt the meals if patients had a preference. On all the wards we inspected patients who had specific requirements were accommodated, for example, if they were vegetarian or ate a halal diet.

Staff assessed each patient's nutrition and hydration needs using a nutritional and fluid balance screening tool and wrote up care plans to indicate appropriate food and drinks based on all of the wards we inspected, those needs. There were dieticians available to support patients and staff with managing patient's specific and additional nutritional and hydration needs.

**Pain relief**

Patients were assessed using pain scoring and recording charts which were contained within each individual care plan; each pain record we looked at had been appropriately dated, signed and reviewed. Patients we spoke with told us they had received adequate pain relief and that staff reviewed its effectiveness at regular intervals.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Staff were involved in several audits as part of a clinical audit programme. Clinical audit is a way to find out if healthcare is being provided in line with standards and provides feedback to inform patients and providers what the service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients.

Local audit information was displayed on quality boards across the wards highlighting nursing metrics, essential care indicators, last safety thermometer results, patient feedback and cleaning audit results. The quality boards were updated every month to display the most up to date results to share with people on the ward, this included visitors and patients as well as staff. This meant everyone who accessed the ward could see what was audited, what the results were and what changes were made as a result where improvements were identified.

Staff received a scorecard with their key performance indicators each month. In addition, each ward carried out monthly quality metrics called essential care indicators. To complete the quality review, 10 patients were randomly involved in discussions, reviews of their nursing notes, medical notes, risk assessments to ensure standards were being met. One matron told us they would like to see more patient input to improve the quality of care and put patients at the heart of what they do.

**Audits – changes to working practices**

The trust reported participation in 30 clinical audits for community inpatient services as part of their Clinical Audit Programme.

None of the audits apart from the SSNAP were benchmarked, therefore we were unable to make comparisons nationally.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Date/regularity of audit</th>
<th>Key successes</th>
<th>Key areas of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Staffing Audit</td>
<td>November 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUST assessment and care planning</td>
<td>December 2017</td>
<td>Overall good performance in a number of areas</td>
<td>Obtaining details of weight history prior to admission</td>
</tr>
<tr>
<td>Health Records</td>
<td>February 2017</td>
<td>An increase in number</td>
<td>Not all services are</td>
</tr>
<tr>
<td>Audit name</td>
<td>Date/regularity of audit</td>
<td>Key successes</td>
<td>Key areas of concern</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Management (Re-audit)</td>
<td></td>
<td>of services using track and trace systems.</td>
<td>using track and trace procedures.</td>
</tr>
<tr>
<td>Annual Corporate Medical Records (Re-audit)</td>
<td></td>
<td>Met the 85% standard</td>
<td>Continued work in relation to correct record of allergies/gaps and corrections.</td>
</tr>
<tr>
<td>PLACE Audit</td>
<td>Feb-May 2017</td>
<td>On-going monitoring using the mini-PLACE audits</td>
<td>Capital funding to deliver some of the environmental concerns</td>
</tr>
<tr>
<td>Audit Inpatient Services (Yearly Plan Quality Assurance). A Mental Capacity Act/Deprivation of Liberty Safeguards/Safeguarding Audit for Front-Line Staff</td>
<td>September 2017</td>
<td>Overall improvement in working practices</td>
<td>Awareness of the principles of the MCA and capacity assessments needs to be embedded in all aspects of Patient care. Policy development in MCA required.</td>
</tr>
<tr>
<td>Response time audit</td>
<td>August 2017</td>
<td>Adult Safeguarding Service and Duty system is highly valued by staff</td>
<td>More complex cases can become lengthy, increasing demand on the duty system</td>
</tr>
<tr>
<td>Customer satisfaction audit</td>
<td>October 2017</td>
<td>Staff are extremely satisfied with the service they receive</td>
<td>Adult safeguarding continues to grow. This requires that staff have an awareness and understanding of what to do in all aspects.</td>
</tr>
<tr>
<td>Medical Devices Management Audit (Re-audit)</td>
<td>Quarterly</td>
<td>More robust data available has improved equipment ownership</td>
<td>None</td>
</tr>
<tr>
<td>Annual pre-acceptance audit of clinical waste</td>
<td>Annual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In patient Clinical Areas Environmental audit (IPS)</td>
<td>Quarterly</td>
<td>Waste Group meetings commenced</td>
<td>Environment issues, Cleaning sustainability, Non-compliant waste store at MHH, Lack of Storage, decontamination of patient equipment</td>
</tr>
<tr>
<td>Hand Hygiene Observations</td>
<td>Monthly</td>
<td>Staff compliance with hand hygiene.</td>
<td>Staff non-adherence to the 5 moments of hand hygiene specifically on leaving the one patient’s bed area to move onto the next patient.</td>
</tr>
<tr>
<td>Audit name</td>
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<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Commode Audit (Urgent Care)</td>
<td>Monthly</td>
<td>Optimal compliance in December.</td>
<td>Elements of minimal compliance pertained to hard seats, footrests and arms being soiled.</td>
</tr>
<tr>
<td>C.P.E. Audits</td>
<td>Quarterly</td>
<td>Ward 14 remained on the audit for a period of three consecutive weeks. Ward 12 and CU.27 were compliant.</td>
<td>Decontamination of patient equipment.</td>
</tr>
<tr>
<td>Clostridium difficile enhanced</td>
<td>Quarterly</td>
<td>Wards and Intermediate care units are not on the audit for more than six weeks.</td>
<td>Issues pertaining to non-compliance in some areas</td>
</tr>
<tr>
<td>National cleaning specification audit</td>
<td>Monthly</td>
<td>Overall compliance with KPI.</td>
<td>Issues pertaining to the Environment, high and low-level dust.</td>
</tr>
<tr>
<td>Enteral Feeding (IPS)</td>
<td>Monthly</td>
<td>Optimal compliance with audit.</td>
<td>Due to the complexity of patient’s medical conditions in neuro-rehabilitation and duration of stay, it is not always appropriate to train patient’s or carers in the management of enteral feeding.</td>
</tr>
<tr>
<td>Urinary Catheter Care insertion IPS audits (Documentation)</td>
<td>Monthly</td>
<td>Overall compliance with KPI.</td>
<td>Long term urinary catheter being inserted for urinary retention, with no documented medical plan.</td>
</tr>
<tr>
<td>PVC IPS audits Insertion (Documentation)</td>
<td>Monthly</td>
<td>Compliance with KPI.</td>
<td>Partial compliance relates to a doctor not wearing gloves when there is anticipated contact with bodily fluids and not disposing of sharps at point of use.</td>
</tr>
<tr>
<td>Standard Precautions</td>
<td>Monthly</td>
<td>Audit Compliance with RAG rating.</td>
<td>Sharps container being filled above the fill line and sharps container not being assembled correctly.</td>
</tr>
<tr>
<td>Asepsis IPS audits</td>
<td>Monthly</td>
<td>Compliance with KPI.</td>
<td>Non-compliance related to staff member being assessed only partially</td>
</tr>
<tr>
<td>Audit name</td>
<td>Date/regularity of audit</td>
<td>Key successes</td>
<td>Key areas of concern</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Environmental and Standard Precautions</td>
<td>Quarterly</td>
<td>Compliance with KPI.</td>
<td>Decontamination of patient equipment.</td>
</tr>
<tr>
<td>Rapid Improvement IPS Audit</td>
<td>Monthly</td>
<td>Data submitted in a timely manner from ward 1.</td>
<td>Lack of storage, unclean environment and IPC risk assessment has not been undertaken.</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE) - screening and weekly assessment</td>
<td>July 2017</td>
<td>Overall good practice.</td>
<td>Venous Thromboembolism (VTE) reassessment are not routinely completed weekly.</td>
</tr>
<tr>
<td>INRU (inpatient neuro rehabilitation unit) Environmental Audits</td>
<td>Quarterly</td>
<td>Maintaining high level of asepsis to aid prevention of infection. Techniques observed were good.</td>
<td>Pre-planning and preparation of required equipment required.</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme</td>
<td>Quarterly</td>
<td>Maintaining performance as level C for key areas of therapy. Overall good practice.</td>
<td>Continue to be unable to increase frequency and length of treatments in therapy secondary to staffing resource. Performance against targets for continence, mood and cognitive assessments are influenced by referring team and therefore vary.</td>
</tr>
<tr>
<td>UK-Rehabilitation Outcomes Collaborative</td>
<td>Bi-Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit of Rehabilitating Non-Traumatic Spinal Injury Patients</td>
<td>September 2017</td>
<td>People with spinal cord injury made considerable progress in inpatient neuro rehabilitation unit in terms of self-care, mobility, and adjustment to limitations. Results are comparable with other rehabilitation units.</td>
<td>Psychology review - Guidelines states that this should be within 7 days. Only 5 met this guideline.</td>
</tr>
<tr>
<td>Audit name</td>
<td>Date/regularity of audit</td>
<td>Key successes</td>
<td>Key areas of concern</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>There was noticed significant improvement in the level of function</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Audits – Changes to working practices tab)

We reviewed a sample of action plans the trust had implemented because of the above audits. This included adult inpatient services quality assurance, inpatient clinical areas environmental audit, C.P.E audits, national cleaning specification audits and audit of rehabilitating non-traumatic spinal injury patients. We noted there were clear action plans in place which were monitored through the relevant committee.

**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 monitor the effectiveness of the service.

All staff were given a corporate and local induction, completed mandatory training and were given a personal development review. Personal development reviews, professional and clinical supervision were provided. On the neuro rehabilitation and stroke rehabilitation units, staff were provided with psychology led group supervision as an opportunity to reflect, learn and grow as professionals.

Leaders we spoke with told us that there were limited leadership development opportunities for them or senior nurses. One matron told us that they used to meet as a team of matrons with the director of nursing and therapies quarterly, however this no longer happened. They told us that this was an opportunity for them to be included in discussions about what was happening strategically and that it empowered them in their roles.

Staff who required specialist knowledge and skills were provided with training courses to ensure they were competent for the role. For example, staff working with patients living with dementia had dementia training and ongoing support from a dementia lead nurse who provided onsite training and learning and development to staff across all wards. Staff who worked on the neurological rehabilitation wards and stroke wards received specific training to support those patients requiring skills and competencies relating to their specialist needs. We saw documented protected learning time scheduled in staff electronic records to ensure staff could take the time to receive this training.

Staff were included in one-to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation to review their development needs and keep their skills up to date.

Senior staff provided us with examples of where they had identified poor practice and the changes they made as a result. They identified poor practice by carrying out audits, by observing conduct, by encouraging comments and by following policies and procedures. Staff performance was managed by issuing changes across the board, for example, at the enhanced assessment bed service at Good Hope Hospital the new matron observed staff were not always following policy in relation to trust uniform and appearance. This was introduced as a blanket change for all staff and monitored for compliance. Staff were managed individually in one to one meetings and staff were involved in team meetings to outline expectations and feedback learning from audits.

A matron and dementia lead nurse told us they were working on a programme of volunteers and they hoped to introduce them with a package of training and support before the end of the year. The volunteers would provide additional support such as activities/reminiscence therapy to provide a stimulating environment for patients living with dementia. At the time of inspection, the number of
volunteers were low and the aim was to increase this. This meant the trust recognised the value of employing volunteers to provide further support to staff and patients.

Staff, teams and services within and across organisations worked together to deliver effective care and treatment. They worked together to share their skills and to support patients in their rehabilitation and discharge back to the community. There were partners who were based on wards, for example, at the enhanced assessment bed service at Good Hope Hospital, there were two social workers based on the ward which meant they were easily accessible to support staff and patients on this ward.

There were clinical practice development lead nurses to support staff in their roles. These were new roles within the division which supported staff to improve quality, for example, effective care planning and case note reviews.

Senior staff told us that there were protected monies for extra training, for example, palliative care and specific training dementia mandatory awareness and advanced training. Staff on the trauma and orthopaedics unit had trauma and orthopaedics accredited courses. Advanced nurse practitioners were being introduced across community inpatients. The aim was to have an advanced nurse practitioner on each ward and a planned doctor on call at night.

The trust had dedicated link nurses for tissue viability, infection control and dementia. Link nurses took lead roles in knowing and understanding their special interest and sharing this with other staff and were required to complete an internal training programme to carry out this role. This meant that there was a commitment to ensure staff were competent and had additional specialist support to ensure effective care and treatment.

Other external providers attended across sites to train staff in the following areas for example, the use of thickeners, tracheostomy and sepsis. The trust also had a transfusion practitioner who trained staff on blood transfusion and linked closely with colleagues at a local acute trust where they attended transfusion meetings monthly. They kept staff up to date with evidence based practice through research, and eLearning. All of which contributed to the overall competency of staff to improve patient care.

The sepsis screening tool was incorporated on to the electronic patient record (RIO) to support the monitoring and reporting of sepsis. The screening tool was completed by nursing staff and the ward receptionist entered the details onto the RIO.

During 2016/17 posters and leaflets were produced for staff, patients, families and carers to raise awareness of Hospital Acquired Pneumonia and prevention and Sepsis. The patient deterioration chart (NEWS, National Early Warning Score) was revised to include a new communication tool and the Sepsis flags. Implementation was supported with awareness sessions. We reviewed the ‘emerging themes’ 2017 document. It identified:

- Sepsis screening tool was not used as a prompt to recognise and treat sepsis within the hour.
- Unclear record of patient deterioration in the notes - to include the escalation process.
- NEWS not completed correctly
- No care plan to reflect patient was End of Life.
- Timely monitoring and escalation of the diabetic patient
- No date and time on handover documentation between shifts.
- GP not documenting in medical notes.
- Recording patient activity in the wrong patient record (notes)

We saw that there were action plans in place to address these areas of non-compliance. For example, a sepsis plan was in place and a Sepsis/HAP group reported to the Mortality Review and Deteriorating Patients Committee (MRDPC) on an on-going basis and deteriorating patient training was being rolled out.

**Clinical Supervision**
The trust reported that they do not currently collect data regarding clinical supervision activity. A wide range of support for clinical supervision was available in the trust including training, supported action learning, and roadshows. The trust reported it was working with divisions to create a practical method of capturing clinical supervision activity to be able to produce centralised reports. The electronic staff record (ESR) was currently one of the main options, and could be used in the same way as it was used to record professional development reviews Safeguarding supervision was recorded separately and was reported on monthly.

(Source: Routine Provider Information Request (RPIR) – Clinical Supervision tab)

The trust employed a clinical practice development lead nurse who had specialist supervision. They liaised with Birmingham University and part of their role was to support students. We were told that they always tried to be visible and staff we spoke with knew them and understood their role. They were based mostly at Moseley Hall Hospital but also linked in with West Heath Hospital. They had started up a clinical supervision group and were trained to deliver clinical supervision. Staff with specialised roles received role specific clinical supervision. This meant they were supported by staff who had skills in their specialist area to improve their practice.

Appraisal rates

In patient adult services had not complied with its appraisal target. This meant the trust missed valuable opportunities to ensure staff felt motivated, well supported and confident to deal with the many issues and challenges they face in their role and for staff to evaluate their performance, receive constructive feedback, build upon strengths and address any areas for development.

From April 2017 to December 2017, 83% of all staff within the community inpatients services core service had received an appraisal compared to the trust target of 90%. For non-medical staff, this figure was 74%, while medical staff had a completion rate of 100%. The number of medical staff was much lower than the number of non-medical, therefore each medical member of staff accounted for a higher proportion of the total than non-medical staff.

Anne Marie Howes, Perry Trees and West Heath Hospital were fully compliant. Community unit (ward 27) was 64% compliant with nursing showing 61% compliance. The inpatient neuro rehabilitation unit showed an overall compliance of 64% with nursing at 29% compliance. Moseley Hall Hospital was at 89% compliance overall. The nursing staff achieved the lowest compliance of 83%. The urgent care division was at 89%, however nursing staff were at 83% compliance. This showed that the nursing staff were least compliant across the board. Staff on the neuro rehabilitation and stroke rehabilitation units had the highest number of staff without an up to date appraisal. Staff on the neuro rehabilitation ward told us this was mainly due to lack of a stable manager for a substantial period and therefore lack of oversight and capacity of staff ‘acting up’ to complete these. We spoke to managers about targets they had not met for appraisals and were told that all staff were accounted for. Staff who were in the workplace were booked in for an appraisal, staff who were absent for extended periods, for example, due to sickness would be prioritised upon their return. We saw where this had been recorded and the plans in place to ensure completion.

### Community inpatients all staff

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff appraised</th>
<th>Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Staffing group</td>
<td>Staff appraised</td>
<td>Individuals required</td>
<td>Appraisal rate (%)</td>
<td>Trust target (%)</td>
<td>Target met (Yes/No)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>--------------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>16</td>
<td>17</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>23</td>
<td>25</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>44</strong></td>
<td><strong>93%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

The following charts show the appraisals data at site level.

**Anne Marie Howes Centre**

**Community Unit 27**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff appraised</th>
<th>Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>12</td>
<td>18</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>11</td>
<td>18</td>
<td>61%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total all staff</strong></td>
<td><strong>23</strong></td>
<td><strong>36</strong></td>
<td><strong>64%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

**MHH (INRU)**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff appraised</th>
<th>Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>15</td>
<td>16</td>
<td>94%</td>
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</tr>
<tr>
<td>Additional Clinical Services</td>
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<tr>
<td>Nursing and Midwifery Registered</td>
<td>6</td>
<td>21</td>
<td>29%</td>
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<td>No</td>
</tr>
<tr>
<td><strong>Total all staff</strong></td>
<td><strong>44</strong></td>
<td><strong>69</strong></td>
<td><strong>64%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
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</tbody>
</table>

**Moseley Hall Hospital**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff appraised</th>
<th>Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and Clerical</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Staffing group</td>
<td>Staff appraised</td>
<td>Individuals required</td>
<td>Appraisal rate (%)</td>
<td>Trust target (%)</td>
<td>Target met (Yes/No)</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>--------------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>45</td>
<td>51</td>
<td>88%</td>
<td>90%</td>
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</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>34</td>
<td>41</td>
<td>83%</td>
<td>90%</td>
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</tr>
<tr>
<td><strong>Total all staff</strong></td>
<td><strong>106</strong></td>
<td><strong>119</strong></td>
<td><strong>89%</strong></td>
<td><strong>90%</strong></td>
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</table>

**Perry Trees Centre**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff appraised</th>
<th>Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>30</td>
<td>30</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>11</td>
<td>12</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total all staff</strong></td>
<td><strong>42</strong></td>
<td><strong>43</strong></td>
<td><strong>98%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

**Urgent Care Division**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff appraised</th>
<th>Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and Clerical</td>
<td>21</td>
<td>22</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>27</td>
<td>29</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>14</td>
<td>18</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total all staff</strong></td>
<td><strong>72</strong></td>
<td><strong>81</strong></td>
<td><strong>89%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
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</table>

**West Heath Hospital**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff appraised</th>
<th>Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and Clerical</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>24</td>
<td>25</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>24</td>
<td>26</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>West Heath Hospital</td>
<td>49</td>
<td>52</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

**Multidisciplinary working and coordinated care pathways**

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

Multidisciplinary staff made up the teams across the division. They worked closely using each other’s skills and expertise and with other agencies to deliver effective care and treatment. Staff worked collaboratively with external local providers to ensure patients received person-centred...
care based on their personal needs and preferences. There was an integrated approach to
reduce delayed discharges, avoidable admissions to acute beds and a reduction in residential and
nursing home placements.

There were good examples of multidisciplinary working throughout all services. Patients had
access to specialist teams when it was identified as a need. There were occupational therapists,
speech and language therapists, physiotherapists, podiatrists, dietitians, continence teams, and
specialist neurological input. There were link nurses across disciplines and specialist nurses in
addition to specialists who supported patients. These specialists were available to provide specific
support and training and development to staff to improve skills and patient care.

Multidisciplinary team meetings were held weekly. The teams completed a review of each patient
and set key actions for care planning, rehabilitation and well managed discharge. Staff worked
with their community colleagues to support discharge back to community or another care setting.
The wards were nurse and GP led. Social workers, GP’s, mental health colleagues, and other
healthcare staff worked together to enable appropriate transition arrangements upon discharge.

Patients’ needs were met and other services were offered including dental services and podiatry
visits. This was documented in patient’s notes and shared with the multi-disciplinary teams.

Staff and patients worked with internal and external partners to ensure smooth transition and
discharge. We saw examples of good working relationships with clinical commissioning groups
(CCG’s), local authority social workers and third sector organisations to support patients following
discharge and during the patients’ transition. Families and carers were involved throughout and we
saw this recorded in patient records, through discussion with families and patients. This meant
that there were a wide range of people involved in supporting people throughout their journey
while in hospital and during the patients’ process of discharge.

**Health promotion**

The National Institute for Health and Care Excellence guidance is that smoke shelters and
smoking on hospital grounds should be discouraged. At Moseley Hall Hospital, patients had
access to outside spaces with shelters to smoke. We did see stop smoking posters and leaflets at
the site. Staff told us that they gave stop smoking advice and signposted patients who wanted to
stop smoking to smoking cessation services. This meant that although people could smoke, they
were also given support and guidance to help stop.

Many health promotion initiatives had been introduced trust wide. For example, the
importance of maintaining effective oral hygiene for patients as part of supportive care. Mouthcare
Matters project was initiated April 2018 which was a joint scheme with the Dental Hospital. An
external provider attended the stroke rehabilitation and neurological rehabilitation units to train
staff on dry mouth and mouth care.

The neuro rehabilitation unit had facilities for individual and group therapy including a
physiotherapy gym and well-equipped therapy rooms.

Rehabilitation Assistants on the stroke rehabilitation unit helped patients to regain their confidence
to do everyday tasks. They helped patients to do therapy exercises and to become as
independent as possible.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the
Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and
those who lacked the capacity to make decisions about their care.
Staff recorded consent to care and treatment on all records we looked at which was always sought in line with legislation and guidance, we also saw that this was reviewed at regular intervals. Staff received training to understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children’s Acts 1989 and 2004 and other relevant national standards and guidance. This was a mandatory requirement for all staff. We saw that staff recorded possible lack of mental capacity or where patients had capacity in their records. Capacity was reviewed at regular intervals and recorded in patient records.

Staff recognised people who lacked mental capacity and were being deprived of their liberty, and made the appropriate applications to seek authorisation to do so when they considered it necessary and proportionate. We saw evidence of Deprivation of Liberty Safeguards being made in an appropriate way in care records and staff knew and understood the principles. Staff worked with patients to ensure they were treated with kindness, dignity, respect and compassion, and that they were given emotional support when needed. We saw this in our observations, in discussions with patients and their families.

**Mental Capacity Act and Deprivation of Liberty Safeguards training**

The trust set a target of 85% for completion Mental Capacity Act (MCA) training. A breakdown of compliance for mandatory courses from March 2017 to April 2018 for medical/dental and nursing staff within community health inpatient services is below.

**Medical and dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical and dental staff within the community health inpatient services met the completion target for the MCA training course.

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>188</td>
<td>196</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff within the community health inpatient services met the completion target for MCA training.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Deprivation of Liberty Safeguards

Staff provided us with examples of when they had applied for Deprivation of Liberty Safeguards to protect patients while they were on the wards. For example, the neuro rehabilitation unit, we saw there were two patients who were subject to a Deprivation of Liberty Safeguard application. Staff could access advice from the trust safeguarding team over the telephone and did so when they needed it.

The trust told us that trust wide, 83 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority from January 2017 to December 2017. Of the 83 of Deprivation of Liberty Safeguard (DoLS) applications made, 50 related to community health inpatient services.

(Source: Routine Provider Information Request (RPIR) – DOLS tab)
Is the service caring?

At our last inspection of 2014 we rated these services as ‘Good’. At this inspection we maintain the rating as ‘Good’

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff understood and respected patient’s personal, social and cultural needs. Staff spent time interacting with patients and patients reported that care was delivered with kindness and we observed a strong, visible patient-centred culture.

Patients beds were equipped with emergency buzzers. Staff responded to call buzzers in a timely way at two locations, however two patients at Perry Trees Centre told us they might wait a long time for nurse call buzzers to be answered. One patient told us staff late answering the call bell always apologised.

Staff were aware of how to report disrespectful or abusive behaviour. Staff spoken to were aware of a zero tolerance on any behaviour that was threatening, discriminatory or abusive.

Staff ensured side room doors were closed or curtains were drawn during care delivery, interventions and consultations. This promoted dignity and confidentiality. All staff knocked before entering side rooms, again promoting dignity and showing respect for the patient’s circumstances.

The ward had been designed to support patients physical, mental and social wellbeing. This helped to reduce anxiety and confusion and promote a calm and inclusive environment. For example, bed spaces at Willow House did not have numbers, they used pictures instead (for example a bus or a house). This helped to promote patient’s independence and self-care through picture association, which is a helpful tool for people living with dementia.

PLACE - data in relation to privacy, dignity and wellbeing

Teams of NHS and private/independent health care providers undertake these self-assessments, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The 2017 PLACE score for:

- privacy, dignity and wellbeing at the trust is 83.0% which is about the same as the England average overall of 83.7%.

Please note, due to a lack of information, the England average overall score includes all trust types and is not limited to community trusts only.

(Source: Patient Led Assessments of the Care Environment (PLACE))

Emotional support

Staff provided emotional support to patients to minimise their distress.

Patient’s told us and we observed staff were sensitive and compassionate in supporting patients and those close to them. Their needs, both emotionally and socially, were recognised as a priority by staff of all grades and disciplines. Patients were supported to maintain their contact and
relationships with their families, carers and friends. Visiting times in the locations could be tailored to suit the individual's needs.

Patient’s religious needs were met and there was an onsite chapel and a multi faith room which included an ablution area at Moseley Hall Hospital and West Heath Hospital.

Patients had pet therapy sessions and reminiscent musicians attended regularly to some wards to help improve emotional wellbeing. However, this was not available across all wards. One matron told us they were working with the patient experience team to secure additional funds to increase access to pet therapy sessions. This meant more patients could benefit from this type of therapy to improve emotional wellbeing.

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

**Staff involved patients and those close to them in decisions about their care and treatment.**

Patients felt informed about their treatment and were provided with choices about their care and health needs with clear communication. Patients felt listened to, respected and had their views considered where appropriate. Staff were encouraging, sensitive and had supportive attitudes to people who use services and their carers. Information was shared with carers and access to care plan records were located near the patient. Information was shared with a designated family member/carer for patients who lacked capacity and this was clearly documented.

We observed a ward round on the Clinical Decisions Unit at Moseley Hall Hospital. The consultant’s approach was very patient centred and they spoke to patients at length about their care plan, next steps and asked the patient to repeat what was discussed. They gave patients plenty of time to ask questions. One patient we spoke with told us that nothing was too much trouble for those explaining their condition. All the patients we spoke with spoke positively about the consultant.

Family and carers could call any time of the day for an update and felt reassured by the information they were given. Patients carers, advocates and representatives including family members and friends were identified, welcomed, and treated as important partners in the delivery of their care.

Patients and those close to them were aware of who the named nurse was. This was demonstrated with information white boards clearly displaying their named consultant, named nurse and nurse in charge of the ward.
Is the service responsive?

At our last inspection of 2014 we rated these services as ‘Good’. At this inspection we maintain the rating as ‘Good’.

Planning and delivering services which meet people’s needs

The trust planned and provided services in a way that met the needs of local people. The facilities and premises were generally appropriate for the services that were planned and delivered, although certain areas were short of storage space. The services provided reflected the needs of the population served and offered patients flexibility, choice and continuity of care.

The trust employed a cultural advisor who staff could access for guidance relating to the diverse needs of people who used the services. Staff received mandatory diversity training to help them understand diversity. Staff could also access patient individualised care plans that highlighted diverse needs and how they were met. For example, provision to help with communication needs of people with a disability or sensory loss. This was recorded in personal records and care plans. Most of the care plans we looked at were individualised. This meant there were a range of measures in place for staff to understand how to plan and meet the needs of the people who used the services.

Senior staff told us that the service had work to do in improving meeting the communication needs of patients whose first language was not English. We could see on the wards that patients whose first language was not English might not always be able to communicate directly with staff. Staff could access translation services by telephone or face to face for planned communication. Where possible they used staff employed at the trust who spoke the same language. Patients did have communication cards with symbols to communicate simple information. Where possible and appropriate, staff involved families in communicating with their loved ones about day to day routines. Families were not used as an alternative to employed translation services. For example, a patient on the stroke rehabilitation ward had family support on site 24 hours a day. This meant the patients’ needs were being met with family to communicate directly to staff.

Literature for religions was available at Moseley Hall Hospital, however it was limited to Christianity and did not reflect the diverse nature of the local community. Staff were aware how to contact chaplaincy in and out of hours to support patients.

Bed moves

The trust were asked to provide information regarding ward moves for a non-clinical reason during the last 12 months. For example, if a patient had to move wards several times because there was no room in the speciality ward they should be on.

No data was reported for community inpatient service bed moves. During the inspection the service lead could confirm that no patients were moved for non-clinical reasons.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Bed moves at night

Patients were only moved if it was clinically appropriate.

The trust were asked to provide information regarding ward moves between 10pm and 8am for each core service for the last recent 12 months.

The trust reported no community inpatient services bed moves at night between January 2017 and December 2017.
Mixed sex breaches

Mixed Sex Breaches are defined by the Care Quality Commission (CQC) as a breach of same sex accommodation, as defined by the NHS Confederation definition. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages, and therefore includes children's and adolescent units. This means that males and females should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be in the event of a family admission on a children’s unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

We saw that patients did not share bedrooms or bays and that some wards consisted of single sex bays. We asked the trust to confirm where wards were mixed sex, to confirm what risk assessments and assurances were in place to ensure the safety and suitability of the environment for male and female patients. The trust confirmed that there were ensuite individual bedrooms with gender designated bathrooms and toilets on the main corridors at Perry Tree Centre and Ann Marie Howes Centre. CU27 and wards four, five, six, seven and eight at Moseley Hall Hospital Hospital had separate wings for male and female patients with identifiable designated bathrooms contained in the appropriate area. The wards at West Heath Hospital and Ward nine (INRU) had designated bays for female and male patients with designated bathing facilities. Although the trust were compliant with same sex accommodation and declared this on a monthly basis to commissioners, the trust did not provide us with any risk assessments or assurances regarding the safety and suitability of the environment.

Community inpatient services reported no mixed sex breaches during the period from January 2017 to January 2018 and declared compliance with mix sexed accommodation standards on a monthly basis to clinical commissioning groups. The review of compliance formed part of the trust’s annual audit programme and each bedded unit received an assessment following the template developed by the NHS Institute for Innovation and Improvement.

Meeting the needs of people in vulnerable circumstances

All services made reasonable adjustments to ensure accessibility for people with a disability, impairment or sensory loss. There was disabled access, hearing loops for those with hearing impairments. ‘This is me’ booklets were created by patients and their families to inform staff who worked with them about their personal history and preferences. There were dementia friendly environments and resources across the trust. All the wards we visited had one large shared screen which patients could be taken closer to by a staff member. It also had wheels so it could be taken to the patient’s bedside/dayroom, however Willow House patients who were primarily patients living with dementia had access to touch screen monitors in the form of either a large screen or table. This helped patients with impairments play board games, access their budgets and go shopping. They could play piano on it and access music and film from their preferred era.

Staff actively used the ‘this is me’ booklet for patients who had dementia, delirium or other communication difficulties. It was a simple and practical tool that people living with dementia used to tell staff about their needs, preferences, likes, dislikes and interests. The booklet enabled all professionals involved in the patient’s care to see the person as an individual and deliver person-centred care that was tailored specifically to the person's needs. It could reduce distress for the person with dementia and their carer. It could also help to prevent issues with communication, or more serious conditions such as malnutrition and dehydration.
Access to the right care at the right time

Based on the 18-week national referral to treatment target for consultant-led compliant services, people could access the service when they needed it and waiting times from treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Patients had timely access to initial assessment, test results, diagnosis, and treatment. For example, at Moseley Hall Hospital there was a 12 bedded clinical decisions unit. Patients were referred from the community or acute hospitals to have an assessment and then went to the appropriate place for their condition. This was a short stay unit with an average length of stay 72 hours.

Referrals

Birmingham Community Healthcare NHS Foundation Trust does not have analysis of referral to treatment and onset of treatment. They also do not have internal targets for referrals to treatment, but do adhere to the national referral to treatment target for consultant-led compliant services of 18 weeks.

The trust had identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The table below shows the number of days from referral to face to face contact. These were within the national referral to treatment target for consultant-led compliant services of 18 weeks.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of in-patient ward or unit</th>
<th>Days from referral to face-to-face contact – Actual (median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moseley Hall Hospital</td>
<td>Assessment and treatment service</td>
<td>68</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Musculoskeletal service</td>
<td>87</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Nutrition and dietetics</td>
<td>82.5</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Podiatry</td>
<td>77</td>
</tr>
<tr>
<td>Community (multiple sites)</td>
<td>Stroke medicine</td>
<td>12</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Referrals tab)

Waiting times

The trust reported the longest average waiting time within community inpatient services was the inpatient neurological rehabilitation unit with 53 days. However, they stipulated that this had not been validated due to timescales for completion.

(Source: Routine Provider Information Request – Waiting times tab)

Bed occupancy

The trust provided information regarding average bed occupancies from January 2017 to December 2017. The average bed occupancy for the core service as a whole was 89%. Details of bed occupancy rates at individual sites can be found in the table below:

<table>
<thead>
<tr>
<th>Team</th>
<th>Average bed (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Heath Hospital - WHH Sub-Acute Ward 14</td>
<td>97% (94%-99%)</td>
</tr>
<tr>
<td>Perry Tree Centre – INCU</td>
<td>92% (82%-97%)</td>
</tr>
<tr>
<td>Community Unit 27 – INCU</td>
<td>91% (79%-98%)</td>
</tr>
<tr>
<td>Moseley Hall Hospital- MHH Sub-Acute Ward 6</td>
<td>91% (84%-99%)</td>
</tr>
</tbody>
</table>
The trust provided information for average length of stay from January 2017 to December 2018. The average length of stay for the core service was 33 days. The following table shows the average length of stay in community inpatients at individual sites, measured in days. There is no comparative data to compare this to other community trusts that provide community inpatients services.

<table>
<thead>
<tr>
<th>Team</th>
<th>Average length of stay (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Heath Hospital - WHH DFU Willow House</td>
<td>26 (17-32)</td>
</tr>
<tr>
<td>Ann Marie Howes Centre – INCU</td>
<td>27 (18-32)</td>
</tr>
<tr>
<td>Moseley Hall Hospital- MHH SSTRK Ward 8</td>
<td>50 (35-77)</td>
</tr>
<tr>
<td>Moseley Hall Hospital- MHH Sub-Acute Ward 5</td>
<td>38 (22-33)</td>
</tr>
<tr>
<td>Moseley Hall Hospital- Ward 9 INRU</td>
<td>30 (22-33)</td>
</tr>
<tr>
<td>West Heath Hospital - WHH Sub-Acute Ward 14</td>
<td>30 (17-36)</td>
</tr>
<tr>
<td>Ann Marie Howes Centre – INCU</td>
<td>27 (22-33)</td>
</tr>
<tr>
<td>West Heath Hospital - WHH DFU Willow House</td>
<td>26 (17-32)</td>
</tr>
<tr>
<td>Moseley Hall Hospital- MHH Sub-Acute Ward 5</td>
<td>25 (22-34)</td>
</tr>
<tr>
<td>Moseley Hall Hospital- CCDU (MHH 4)</td>
<td>3 (1-4)</td>
</tr>
</tbody>
</table>

The trust monitored average length of stays during quarterly performance meetings between the divisional management team and clinical team for a specified area. The trust measured length of stay using two indicators, one for neuro-related patients (due to their expected longer length of stay) and all other inpatients.

**Delayed discharges**

The trust identified that there was a risk of increased delayed discharges due to social care capacity within the local health system and had actions in place to monitor this.

From January 2017 to December 2017, there were 694 delayed discharges within this core service. This amounts to 30.7% of the total discharges (2,261). Of the 694 delayed discharges, 452 (65%) were attributable to social care packages, 88 (13%) were attributable to patient / family exercising choice and 44 (6%) were attributable to the need for community equipment.

To manage delayed discharges, leaders had weekly monitoring discussions in relation to delays with commissioners, social care and health partners. Staff worked with patients and their families to manage the challenges of delayed transfers. There was a formal policy around patient choice which was shared with patients and relatives on the day of admission. There were many regional issues that could make discharges complicated. Staff involved social workers to support them...
where possible by attending discharge delays meetings. This meant that there was a recognition of the challenges and processes in place to manage them.

The graph below shows the trend of delayed discharges across the 12-month period. The graph shows a downward trend during the reporting period.

**Delayed discharge trends from January 2017 to December 2017 at Birmingham Community Healthcare NHS Foundation Trust**

(Source: Routine Provider Information Request (RPIR) – Delayed discharges tab)

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

People who used the services were encouraged to raise concerns and make complaints. Staff tried to resolve complaints locally and informally before proceeding to formal processes. Issues raised were investigated and lessons learned were shared with all staff to improve the quality of care. Patients and carers were advised how they could make a complaint or raise a concern on a leaflet or feedback form. They could also complain using the trust’s internet site.

The trust employed a complaint lead who had day to day responsibility for the complaints team. They were responsible for coordinating and processing formal complaints and tracking the effective management of complaints and concerns. Service leads and serious concerns investigated complaints were investigated in line with root cause analysis methodology; this was a process to identify possible causal factors.

There were examples of how people’s concerns and complaints were listened and responded to and used to improve the quality of care. This information was displayed in public areas on quality boards. Patients and their families also gave us examples of when staff had listened and made changes to meet their individual needs. For example, a family who were keen to be with a patient 24 hours a day were permitted to do so with the support of staff and approval of other patients. Staff sometimes recommended useful resources. For example, equipment needed to get patients out of bed were identified as useful and the funds were provided to buy them.
Complaints
From January 2017 to December 2017, the trust reported complaints in the following locations:

- **Moseley Hall** – 10 complaints
  
  Themes included:
  - Flawed discharge processes
  - Poor care
  - Parking bay policing
  - Poor communication

- **West Heath Hospital** – five complaints
  
  Themes included:
  - Poor levels of care
  - Incorrect dosage of medicine

- **Community Unit 27** – three complaints
  
  All three complaints concerned the level of care given to patients

- **Ann Marie Howes Centre** – two complaints
  
  Both complaints were regarding poor level of care received.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

Of these complaints, 11 were partially upheld, three were upheld, two were withdrawn, two were not upheld and two did not require further action taken.

The trust responded to complaints and took action where necessary, for example the implementation of new falls risk assessment documentation, updating doctor’s induction programme to include talking with family members regarding sensitive issues and a recliner chair was purchased for use on ward six at Moseley Hall Hospital.

Compliments
From January 2017 to December 2017, the trust reported compliments in the following locations:

- Moseley Hall Hospital – 77 compliments
- West Heath Hospital – 18 compliments
- Kingswood Drive – one compliment

The trust did not provide individual descriptions for compliments; however, at a trust wide level they had identified the main themes of all compliments as being:

- Praise for levels of care
- Caring attitude of staff – helpful, professional, kindness, compassion, patience
- Staff going extra mile
- Great service
- Quality of service
- Fantastic team
- Knowledgeable, experience, professional staff
- Felt listened to

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*
Is the service well-led?

At our last inspection of 2014 we rated these services as ‘Good’. At this inspection we maintain the rating as ‘Good’

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

All wards were matron led and there were additional staff, for example, clinical ward managers available to guide and support staff. All staff we spoke with told us that managers at ward level were visible and approachable. Staff told us that managers at divisional leadership level were less visible. For example, the divisional leadership team worked as a triumvirate and were less likely to be seen on the wards. The division had general managers to manage activity for example, capital bids, finance, budgets, performance who reported to deputy divisional director. This meant that there was additional operational support to manage performance.

Vision and strategy

The trust were working towards refreshing a vision for what it wanted to achieve and developing workable plans to turn it into action with input from staff, patients, and key groups representing the local community.

Strategic direction and vision and values were being refreshed. The trust had been in the process of an integration programme by acquiring other local trusts and becoming one organisation. The three trusts agreed the decision not to proceed. This meant that the vision, values and the trusts strategy had to be revisited, refreshed and re-established. One of the benefits of the integration would have been better access to mental health services and support, however, leaders told us they were confident that trust strategic objectives would link with the local mental health trust instead and that work had already started. The new chief executive introduced a communication programme to develop the trusts vision, values and strategy. Staff were invited to an event to talk about vision and values to contribute to their overall development. All staff we spoke with told us they felt no significant impact from the integration not happening.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Nursing staff told us they felt positive and proud to work in the organisation. They said they felt supported, respected and valued. On ward CU27, staff told us they felt there had been improvements in the culture of the ward following the recent appointment of a new matron. We spoke with two ward clerks who were very positive about culture. Four healthcare assistants we spoke with told us they felt less valued mainly due to lack of development opportunities in their role.

Staff told us they felt they could be open and honest at all levels within the organisation, including with people who use services. They felt there was a culture of encouragement to raise incidents and learn from them without blame. There were embedded processes and procedures in place to ensure they met the duty of candour requirements. For example, training, support for staff, policy and audits.

There were mechanisms for providing all staff with the development they needed. This was achieved during appraisal and career development conversations. There were staff development initiatives, for example, nurses and therapists could benefit from a fast track career development programme. Nurses were supported and funded to complete advanced nurse practitioner qualifications and offered a role upon completion.
Leaders told us that there was limited scope for leadership development programmes for those staff at matron level. One of the five matrons we spoke with had completed an internal leadership level training course. This meant that not all leaders had been supported in ensuring they were suitably trained in leadership and management to support them in their roles.

Staff were supported in their personal wellbeing. We saw this evidenced in the trust’s flexible approach to staffing hours and flexible working contracts. Staff were also provided a confidential welfare service and occupational health service to support staff with their overall wellbeing and health.

The trust demonstrated its commitment and compliance with the Specific Equality Duty by producing and publishing information showing compliance with the Public-Sector Equality Duty set out in the Equality Act 2010. We saw this on their website and set out in the policies and procedures. We also saw this demonstrated in their commitment to involve staff in engagement with the development of strategy.

There were collaborative and supportive relationships among staff and different wards. They did this by sharing responsibilities, sharing skills and expertise and working across wards and hospitals to provide staff and support discharge.

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. There were clear divisional governance arrangements and there were teams and accountable personnel to oversee governance. There were clear and effective processes for managing risks, issues and performance. This was in seen in their evidence based practice, competency and skills mix of staff and in their documentation and minutes from meetings.

The governance committee had a standard agenda item relating to a learning from deaths. This was where data from deaths in both hospital and the community was being collected and lessons learnt shared. Committee members identified the trust was not sharing learning as well as it might and there were missed opportunities to learn from internal and external mortality reviews. This meant the trust had recognised there were areas for improvement and made recommendations to improve.

Governance meeting minutes were shared and information disseminated to staff at local team meetings. Topics covered included incidents, complaints, audit results and lessons learned.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Leaders of the service had set up a spreadsheet to monitor compliance with the Care Quality Commission’s standards. It contained the five domains and key lines of enquiry for each area and then self-assessed against the key lines of enquiry. Team leaders carried out their own assessment. A matron would oversee the assessments and evidence about how they met the key lines of enquiry with focused on how they could be good to outstanding. They would also set out actions for areas where they assessed themselves as requires improvement. Staff met every two weeks and mapped progress at governance meetings. This meant that staff were focussed on continuous assessment of effectiveness and worked to make improvements.
There was a robust and systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. We saw this evidence in risk registers, governance meetings, following audits and local meetings. There was alignment between the recorded risks and what staff said was on their worry list. For example, standards of cleanliness because of local authority buildings and estates and facilities.

Potential risks were considered when planning services, for example where there were seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. We were told that to manage staffing and improve patient care, there were reduced beds and increased staffing levels. Bed numbers were increased to accommodate winter pressures and a staffing uplift was agreed. One matron told us that they regularly looked at acuity of patients and did a comparison across other areas. Community inpatient services were trialling increasing staff to manage patient acuity.

We were provided with examples of when leaders in the organisation had managed conduct and performance issues that impacted on patient care, the culture and effectiveness of the organisation and staff. There were systems and processes in place to monitor performance regularly through a combination of audit, clinical, peer, specialist and management supervision. Staff used essential care indicators to monitor current performance and make improvements. Each ward had a target to achieve 90% compliance. Those falling short of the target, were provided with additional support by management to improve performance. This meant that there were good governance arrangements in place to manage the risks, issues and performance of staff.

Staff contributed to the risk register which outlined risks including cause, effect and impact. Risk registers were reviewed monthly at divisional meetings and risks were discussed at monthly governance meetings.

**Information management**

Leaders met monthly to discuss quality and risk information about the community services for adults. We saw actions, progress on action and how are they were tracked recorded in monthly minutes from meetings. Performance was monitored at meetings which included people’s views with information on quality, operations and finances.

Staff used information technology systems to ensure they could record information, improve communication and keep up to date with trust developments. Staff had trust email accounts and access to the intranet and internet to access policies, practices and guidance. Staff could download an application to access work rotas and be flexible in the approach to bank work.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Staff were actively engaged through the ‘big conversation’ to make sure their views were reflected in the planning and delivery of services and in shaping the vision and values of the trust. The trust had a position statement relating to mainstreaming equality, diversity and human rights. Staff engagement was routinely carried out on the workforce and those using trust services to gain their feedback or involvement on trust activity. The key mechanism was annual staff and patient surveys.
Staff received a newly introduced divisional newsletter to keep them up to date with changes across the division. Staff contributed to the content of the newsletter. There were lots of examples of how staff contributed to patient rehabilitation, with one example of a patient with a brain injury who had returned to work with a package of care. There were examples of staff involved in research and innovation. The newsletter demonstrated staff were engaged at varying levels in innovation and celebrating positive patient outcomes across the trust.

There were 'you said, we did' boards that displayed information and feedback from people who used services using friends and family test cards and feedback. At Perry Trees Centre there were 'values in practice' staff awards displayed for all people on the ward to see. This was where patients nominated individuals who demonstrated examples of good practice.

There were many examples of initiatives that promoted positive and collaborative relationships. At Moseley Hall people supported ‘John’s campaign’. This was an initiative that actively involved families to keep them involved in all aspects of their family members care. A ‘passport’ allowed open visiting times for families whose family member lived with dementia, any confusion or language barrier and anxiety and depression. Families were invited to ‘dementia action week’, where staff and others were involved in fundraising, for example, skydives for dementia. A questionnaire was undertaken for patients on how the dementia ward works and the results shaped how the new ward was built.

At Moseley Hall we saw a they had implemented a huddle for staff every morning on the ward. This included housekeepers, ward clerks, nurses, consultants and everyone was encouraged to contribute. Staff we spoke with were very proud of this and had a display board in the corridors on the wards. This was rolled out across wards 5,6,7,8 and 9 and we were told it was a boost for staff morale. Staff took this from the Charles Vincent model (a framework for sharing and shaping improvement and patient safety) and had been shortlisted for a ‘values in practice’ trust award as a result.

**Learning, continuous improvement and innovation**

*The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.*

We saw evidence of leaders and staff engaged in continuous learning, improvement and innovation which included participating in appropriate research programmes. For example, research for better outcomes for older people with spinal trouble and control trial research comparing clinical and cost effectiveness of transforaminal epidural steroid injection to surgical microdiscectomy for the treatment of chronic radicular pain secondary to prolapsed intervertebral disc herniation: Nerve Root Block Versus Surgery (NERVES). This meant that staff were involved in continuous improvement and innovation.

In 2017 the trust had been awarded four research awards. Two of the awards were for ‘Highly Commended Best Overall Research Performance Award 2017’ and ‘Being Research Active – Supporting the CRN: West Midlands Ageing Speciality’. This meant that the trust had been recognised nationally for carrying out research and being innovative.

The trust rolled out a multifactorial risk assessment programme trust wide and had been nominated for a national Patient Safety Awards 2018. The results from an audit from the work was requested as a good practice example for the National Quality Improvement and Clinical Audit Network forum.

Staff had opportunities to work together to resolve problems and to review individual and team objectives, processes and performance through team days and organised group development
sessions, for example, on the ward 8 and 9 staff could access group work programmes to improvement. There was a practice development nurse who also worked with staff to ensure best practice was shared and improvements made based on evidence based up to date practice.

**Accreditations**

NHS Trusts could participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The trust had reported that no services within community inpatients services had been awarded an accreditation.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)