Birmingham Community Healthcare NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

Birmingham Community Healthcare NHS Foundation Trust delivers community-based healthcare services to the1.1 million residents of Birmingham. In addition, the trust provides universal and specialist services to 5.5 million people across 103 square miles of the wider West Midlands region, including Sandwell, Dudley and Walsall.

Over 100 clinical services are delivered from hospitals, health centres, clinics and peoples' own homes.

We carried out an unannounced focused inspection of the children, young people and families' service at Birmingham Community Healthcare NHS Foundation Trust on 13 June 2019, to review the assurances we had received relating to a Section 29A Warning Notice, particularly looking into caseload sizes and staffing levels within the health visiting service.

We did not inspect any other core services of Birmingham Community Healthcare NHS Foundation Trust.

We inspected using our focused inspection methodology, particularly looking at the safe domain. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

This was a focused inspection to review evidence of assurance relating to the community health services for children and young people, particularly focussing on health visiting. It took place between 9am and 5pm on 13 June 2019.

We did not inspect the whole core service therefore there are no ratings associated with this inspection.

There were areas of poor practice where we told the trust they need to make improvements.

- The service must ensure it reduces its health visiting caseload sizes to meet the trust target and work towards the national guidance.
- The service must ensure it reduces its complex health visiting caseload sizes to meet the trust target.
- The service must ensure cases involving potentially vulnerable children are handed over in a timely manner when they need to be.
- The service must ensure that when risks are identified cases are correctly categorised when additional health visitor input is required.
- The service must ensure that risks are always recorded and appropriate alerts are raised in care records.
- The service must ensure that the system to maintain a duty health visitor is followed across the service.
- The service must ensure that it has safe staffing levels.

In addition the trust should:

- The service should ensure it assesses the impact the geographical working has had on its health visiting staff.

Following this inspection, we sent a letter raising our concerns. In response to our letter, the provider took some immediate actions to address the concerns we raised.

We told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with a Section 31 notice to the trust which is an 'urgent notice of decision to impose conditions on their registration as a service provider in respect of a regulated activity'. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for children, young people and families		We carried out an unannounced focused inspection of community health services for children and young people services in response to concerning information we had received in relation to care of children, young people and families in this department. We did not inspect any other core service or wards at this trust. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Summary of findings

Contents

Summary of this inspection

Background to Birmingham Community Healthcare NHS Foundation Trust

Birmingham Community Healthcare NHS Foundation Trust (BCHC) delivers community-based healthcare services to the1.1 million residents of Birmingham. In addition, the trust provides universal and specialist services to 5.5 million people across 103 square miles of the wider West Midlands region, including Sandwell, Dudley and Walsall.

Over 100 clinical services are delivered from hospitals, health centres, clinics and peoples' own homes. These include services for adults, services for children and young people, inpatient services, end of life services, community dental services and learning disability services.

The trust was first registered with Care Quality Commission in March 2011 and achieved foundation trust status in 2016.

We carried out an unannounced focused inspection of the children, young people and families service at the Birmingham Community Healthcare NHS Foundation Trust on 13 June 2019, to follow up a section 29A warning notice that was issued to the trust in August 2018 following a comprehensive inspection.

We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

We previously inspected the community health services for children and young people service at the Birmingham Community Healthcare NHS Foundation Trust in May 2018. We rated it as Inadequate for Safe and Well Led and Inadequate overall. Following the June 2019 inspection, we issued a Section 31 notice to the trust which is an 'urgent notice of decision to impose conditions on their registration as a service provider in respect of a regulated activity', and a requirement notice.

Our inspection team

The team that inspected the service comprised of Katherine Williams, Inspection Manager, three other CQC inspectors, and one special advisor. The inspection was overseen by Victoria Watkins, Head of Hospital Inspection.

Information about Birmingham Community Healthcare NHS Foundation Trust

The trust has a range of accessible 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 aims to support every child from pre-birth to five years old by health visiting teams, which were part of the new Early Years Health and Wellbeing service, together with Children's Centres, from January 2018. This is part of the government initiative to make sure all children are provided with early years healthcare; and that it is run via an integrated care model at Birmingham Community Healthcare NHS Trust.

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.

Summary of this inspection

Regional Child Health Information and Paediatric Sexual Assault Services were also provided by the Trust.

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.

During this focused inspection we focused on the health visiting service due to concerns raised with us through our intelligence services. We undertook focus groups with Health Visitors prior to the inspection as part of our routine trust engagement.

We spoke with one operational manager, two team leaders, 13 health visitors, two assistant practitioners, two administrative workers, observed a clinic where mothers had appointments with the health visiting service, observed two home visits and spoke with two service users. We also reviewed six care records.

Community health services for children, young people and families

Safe

Summary of findings

We did not rate the safety of the service on this inspection. We found that:

- The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep children young people and families safe from avoidable harm and to provide the right care and treatment.
- Staff did not always complete and update risk assessments for each child and they did not remove or minimise risks.
- Staff did not always identify and quickly act upon children at risk of deterioration.

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

Assessing and responding to patient risk

Staff did not consistently complete and update risk assessments for each child and young person and did not always take action to remove or minimise risks. Staff did not always identify and act upon children and young people who were at risk of harm.

Health visitor caseload sizes were impacting on health visitors' ability to effectively assess and respond to children, young people and families' risks.

Health visitor caseloads were much higher than national guidance suggested, so we were not assured that staff had the time to assess the risks to the health, safety and wellbeing of children, young people and families. As a result, we were also not assured that staff were able to mitigate those risks.

Guidance from the Institute of Health Visiting recommends a safe caseload limit as being 'a maximum caseload of 250 children per WTE.' The trust set its caseload target at 360 per wholetime equivalent (WTE) member of staff. However, as of May 2019, the average caseload per WTE health visitor across the entire service was 479 this was nearly double the recommended safe caseload.

We asked the trust about this and they reported that national guidance from the Royal College of Nursing (RCN) states that 400 children 'must be the absolute maximum caseload size' and that the 'average and more normal caseload size should be no more than 250 children'. However, the service was still not meeting either of these figures.

The trust reported that the caseload figures were distributed amongst health visitors, team leaders and district practice leads. Team leaders were expected to undertake 20% clinical activity and district practice leads

were expected to spend 50% of their working time on clinical activity. We did not receive assurance that all team leaders were undertaking the 20% of clinical activity.

The highest district caseload was 619 per WTE (Yardley) and the lowest 391 per WTE (Ladywood). Throughout May 2019 the equivalent of 10.6 full time health visitor roles were filled by bank health visitors. When bank hours were included the average health visitor caseload was 458 citywide. This was higher than the trust target of 360 per WTE health visitor, and significantly higher than national recommendations. All staff we spoke with told us caseloads were too high. Some staff told us they felt that families were at risk because of this. Staff told us these shortfalls in staffing led to them being behind with visits and paperwork.

All teams within the service had caseload sizes above the trust target. The service categorised caseload levels using a red, amber and green (RAG) rating system, with green being 350 or below, amber being 351 to 449 and red being over 450 caseloads per WTE. There were 10 teams within the service, six were rated as red and four were rated as amber.

The trust based its caseload target of 'no more than 360' on national benching marking data and demand and capacity evidence rather than national guidance, which is why the target caseload size per WTE was much higher than the Royal College of Nursing and Institute of Health Visiting guidance.

As a result of the above reported case load figures, and from speaking with staff, we were not assured that staff had the time to assess the risks to the health, safety and wellbeing of children, young people and families and do all that was possible to mitigate those risks.

Some health visitors had a high level of cases where children and families required extra attention. Some health visitor caseloads were categorised as universal plus (UP) or universal partnership plus (UPP), with each case being categorised as having an additional level of need. The service categorised UP and UPP combined caseload levels using a red, amber and green (RAG) rating system, with green being below 35, amber being 36 to 40 and red being over 40 caseloads per WTE.

There were 10 teams within the service, four were rated as red, two were rated as amber and four were rated as green. This meant that over half of the health visitor teams within the service had caseloads above what the trust determined to be the appropriate number. The average UP and UPP combined caseload for the service was 36.

There was evidence within the care records and in incidents we reviewed to show that children were not being categorised correctly and therefore did not have all interventions necessary to keep them safe. Children who had factors that increased levels of need for them and their families were categorised as universal which meant they only received the basic level of input from health visitors.

On inspection we found that not all caseloads were identified and allocated out when a staff member was away from work; for example, if away from work due to illness. This meant vulnerable children were not being reviewed in a timely way and there was no oversight of this issue. Following our inspection the trust provided data that demonstrated safeguarding cases were now being allocated to health visitors.

From July 2018 to June 2019 there had been 21 incidents reported through the trust's electronic reporting system relating to caseloads. The main themes identified by the trust were complexity of caseload, lack of capacity and impact on wellbeing. The trust undertook a review into unallocated cases which led to several clarifications around the role of the duty health visitor.

Staff did not always know about and deal with specific risk issues. An investigation into a recent incident indicated that staff at the trust were not always appropriately identifying risks to children, young people and families. Whilst on inspection we were informed of an incident that had occurred and requested related documentation from the trust. In the investigation and root cause analysis that followed it was clear that the child involved, and their family had been incorrectly risk assessed and as a result had been allocated to a universal rather than universal plus or universal partnership plus caseload. This meant the family involved received less health visitor input than they should have received based on the risk factors involved. At the time of our inspection this case was awaiting review to see if it met the criteria of a serious incident. The trust sent out a 'lessons learnt' newsletter advising health visitors to

'ensure they were clear about the difference between universal/universal plus and universal partnership plus before allocating the status to a child' following this incident.

Staff did not always complete risk assessments for each child and young person on admission and did not always update them when necessary. Records we reviewed indicated that risks to children, young people and families were not being appropriately documented. As a result of this, anyone taking over these cases would not be fully aware of the risks to the children, young people and families.

Whilst on inspection we reviewed six case records for vulnerable children and found issues which included; two incidents of appropriate alerts not on the records, a care plan that had not been updated since 2016, one example of notes written retrospectively; four and five days after meeting and a record of an Initial Child Protection Case Conference (ICPC) that had taken place with no date or details of the outcome. These issues all reduced the health visitors ability to effectively assess and respond to children, young people and families' risk.

Staff told us they regularly did not have time to complete records in their working hours. Staff had to either complete records at home on their laptops or come in to work early in order to keep up with the workload.

The trust provided the most recent records audit data. Trust audit data indicated 35 areas of record keeping practice had increased in compliance, two had remained the same and six had decreased in compliance. This did match the findings from our records review where we found several issues in a small sample size.

The service had made changes which had impacted on staffs' ability to effectively assess and respond to the risk to children, young people and families. The way geographical working was implemented was impacting negatively on health visiting staff and reducing the effectiveness of the service that they provided. Staff provided an example of a missed new birth appointment which was missed due to confusions over geographical working and poor communication. The child was visited by a health visitor following this issue being raised through the trust's electronic reporting system.

Staff felt that leaders did not understand the impact that geographical working was having on frontline staff. Staff told us that travel times had increased and they were travelling to appointments that were close to other health visiting bases and teams. Staff told us they did not know the local communities in which they were working sometimes so could not signpost families effectively. The trust told us they had planned to undertake an audit into the impact of geographical working on 30 September 2019.

During our inspection, we observed staff discussing risks with children, young people and families. We observed staff discussing risks during clinics and discussing factors that affected the health and wellbeing of children. The Personal Child Health Record, also known as the PCHR or 'red book', is a national standard health and development record given to parents or legal guardians at a child's birth. Staff updated red books during appointments. Staff we spoke with had received training and had a good knowledge of safeguarding and understood their responsibilities.

Staffing

The service did not have enough health visiting staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment.

The service did not have enough health visiting staff to keep children and young people safe. This contributed to increased risk as caseload sizes for health visitors remained high across the whole service. As of 31 May 2019, the overall staffing level for the service was 174.55 whole time equivalent (WTE), which moved up to 182.1 WTE with the additional capacity provided by the bank service.

The establishment level for band six health visitors across all the teams was 227 WTE. The effective rate had fluctuated up and down since May 2018 between 187.76 (May 2018) and 172.06 (April 2019).

Whilst on inspection we visited three teams across Birmingham. All three teams we visited were significantly below the agreed staffing establishment.

Low staffing levels negatively impacted staff across all teams. One of the ways this impacted on staff was that there was increased workload and this in turn increased

the risk to children, young people and families. Staff told us they felt staffing was putting families at risk as they were not seen in a timely manner. This is consistent with risks we found on inspection.

We observed a clinic operating below establishment level and observed that records were not completed in a timely manner. Staff told us clinics also took place with assistant practitioners and no health visitor present. Staff told us that health visitors were leaving the role regularly and this was impacting on workload. Staff told us they would struggle to respond as effectively to risks and mitigate them as well as they have done in the past due to the staffing shortfalls.

The service was growing increasingly dependent on the use of bank staff to try and manage caseload sizes**.** As of May 2019, the bank use across division was 11.54%. This equated to 10.6 WTE bank usage in May 2019. The bank rate for band six health visitors had fluctuated up and down since March 2018 however, the overall bank usage rate had increased by 5.34 WTE from 5.43 WTE. The highest rate use of bank and agency staff was 11.66 WTE in March 2019.

The trust had introduced some mitigating actions to support teams with the lowest staff numbers. The trust filled staffing gaps by loaning health visitors between teams in circumstances where staffing levels were far below establishment. At the time of our inspection three WTE health visitors were 'on loan' from their substantive teams to Hodge Hill and Yardley health visiting teams. Individual staff were loaned for three months, on rotation with other members of the wider health visiting teams. The trust only moved staff between teams after they had assessed it was safe to do so.

Staff vacancy rates and turnover had increased in the year since our previous inspection. This kept staffing levels below establishment and increased pressure on staff and their caseloads. The vacancy rate had increased since our last inspection of the service. As of 31 May 2019, the vacancy rate within the whole division was 11.3%. However, the vacancy rate for band six health visitors was 21.3%. The vacancy rate for band six staff had fluctuated up and down since March 2018 however, the overall rate had increased from 16% to 21.3%. The turnover rate also increased from 9.5% in March 2018 to 12.9% in May 2019. This was the highest it had been during that time period. Staff we spoke with told us that lots of staff had left the service recently. The trust also told us and showed us in evidence provided that they had more staff leave than they expected recently. While on inspection across the three sites we visited, we also confirmed this, by observing that many of the staff rotas still had people on them who had left, were leaving soon or were reducing their working hours.

The staff sickness rate had remained around the same level since the last inspection. As of 31 May 2019, the sickness rate for band six health visitors was 6.95%. The sickness rate had fluctuated up and down since March 2018 between 7.77% (September 2018) and 5.52% (May 2018). Staff told us sickness levels were high across the teams we visited, which added pressure to caseloads for health visitors.

Staff reported incidents relating to low staffing levels. There were 38 incident reports related to low staffing in the 12 months prior to our inspection. The trust identified no harm to children or their families in these incidents. The main themes identified by the trust in these incidents were; lack of capacity to allocate work due to staffing, vacancies, maternity leave and sickness, difficulties with caseload management tools, impact on staff wellbeing, standards of practice, record keeping, and safeguarding issues. The trust identified that more support was needed around communication of changes, caseload tools, an increased focus on staff wellbeing, with focused safe staffing huddles in teams and with operational managers. Newsletters and staffing events were arranged, and huddles encouraged.

The service did not ensure consistency in its duty health visitor cover in offices. This caused delays to families appointments and increased the risk to children as information sharing could be delayed. There was no consistent duty health visitor cover in all the offices across the teams. The duty health visitor role was to be responsible for checking contacts through email, responding to phone correspondence and messages and dealing with people who might walk in to the centres. They would then carry out any actions or distribute any work relating to this. Whilst we were on inspections, we saw there was no assigned staff member to cover this role. Staff were picking up the duty health visitor role as and when they were in the office in between visits which could cause delays in responding if there was no one in the office and we observed this led to a health visitor

being late for an appointment. There could also be long periods with no cover. Team leaders were responsible for monitoring duty health visitors locally. The trust did not formally collect any data as to when there was no duty Health Visitor

The trust had put a plan in place to bring in 20 new band five staff before the end of 2019. At the time of our inspection, they had recruited 16.84 WTE band 5 nurses who were starting between June and September2019.

At the time of our inspection there were 3.16 WTE vacancies remaining. The trust had informed us that team leaders would allocate the band 5 staff a Band 6 health visitor mentor within the team.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure it reduces its caseload sizes to meet the trust target and work towards the national guidance. This was a breach of Regulation 12 (1) HSCA 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.
- The service must ensure it reduces its complex caseload sizes to meet the trust target. This was a breach of Regulation 13 (1) (2) HSCA 2008 (Regulated Activities) Regulations 2014 – Safeguarding service users from improper care and treatment.
- The service must ensure cases involving potentially vulnerable children are handed over in a timely manner when the need to be. This was a breach of Regulation 12 (1) HSCA 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.
- The service must ensure that when risks are identified cases are correctly categorised when additional health visitor input is required. This was a breach of Regulation 12 (1) (2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.
- The service must ensure that risks are always recorded, and appropriate alerts are raised in care records. This was a breach of Regulation 12 (1) (2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.
- The service must ensure that the system to maintain a duty health visitor is followed across the service. This was a breach of Regulation 12 (1) (2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.
- The service must ensure that it has safe staffing levels. This was a breach of Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014 – Staffing.

Action the provider SHOULD take to improve

- The service should ensure it assesses the impact the geographical working has had on its health visiting staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.** **How the regulation was not being met:** • Duty Health visitor was not consistent across the service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	S31 Urgent variation of a condition Regulation 12 (1) (2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment. How the regulation was not being met: • Caseload sizes were not in line with national guidance. • Vulnerable children were not always handed over to health visitors in a timely manner. • Cases were not always correctly categorised so families and children did not receive the correct level of health visitor input. • Risks were not always correctly identified in care records.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	S31 Urgent variation of a condition Regulation 13 (1) (2) HSCA 2008 (Regulated Activities) Regulations 2014 – Safeguarding service users from improper care and treatment. How the regulation was not being met: • Complex caseload sizes were not in line with the trust target.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	S31 Urgent variation of a condition

This section is primarily information for the provider

Enforcement actions

Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014 – Staffing.

How the regulation was not being met:

- Staffing levels were not safe across the teams.