Bromley Healthcare Community Interest Company

Bromley Healthcare Central court

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This was an announced, focused inspection of community health services for children, young people and families and covered some aspects of the safe, effective, responsive and well-led key questions. We undertook the inspection following the death of a baby, who was receiving health visiting services.

We found the following areas of good practice:

- Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so.
- Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.
- The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Managers appraised staff's work performance and provided opportunities for staff to undertake a range of specialist training courses to enhance their role.
- Leaders had the skills and abilities to run the service effectively. They understood and managed the priorities and issues the service faced.

However, the following areas that the service needed to improve:

- Although the service had governance processes that were well developed and embedded into services, we found some areas for improvement. The service had not submitted all required notifications to the Care Quality Commission without delay. The provider recognised the need to ensure notifications were completed promptly and following the inspection introduced some improved processes that would need to be embedded.
- The service safeguarding children's supervision policy was not clear, especially for staff who were new to the role and not familiar with the organisation. Staff did not always complete comprehensive safeguarding supervision notes such as mandatory action plan dates. This meant there was a risk that actions to address risks may have been missed or not completed in a timely manner.
- All staff had access to an electronic records system that they could all update, but a few records did not have up to date child protection information and staff did not always complete patient records in a timely manner.
- Some staff told us that they would benefit from additional training for non-mobile babies to ensure they made informed decisions in different scenarios.

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	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Bromley Healthcare Central court

Bromley Healthcare Community Interest Company is a social enterprise providing NHS community health services, in the London boroughs of Bromley, Bexley, Greenwich and Lewisham. It provides nursing, medical and therapy services for adults and children. These include district nursing, health visiting, speech and language therapy, physiotherapy and occupational therapy. It has a 0 to 19 children's public health service for Bromley and Bexley. The provider took over responsibility for the Bromley 0-19 service from the 1st October 2020. During the COVID 19 pandemic the provider had redeployed some staff.

This inspection was a focused announced inspection of the community health services for children, young people and families core service, particularly the health visiting teams in Bexley and Bromley. The inspection was in response to the unexpected death of a baby from an alleged non-accidental injury and concerns related to safeguarding follow-up. We did not inspect all areas of all key questions and the core service was not given an overall rating. This core service has not been inspected before.

The service has a registered manager in post. The service is registered by the CQC to provide the regulated activities: Diagnostic and screening procedures, Family planning services, Surgical procedures, Transport services, triage and medical advice provided remotely and Treatment of disease, disorder or injury.

How we carried out this inspection

Our inspection team comprised of three CQC inspectors, one CQC assistant inspector and one specialist advisor who was a nurse with expertise in health visiting and safeguarding.

During this inspection we:

- spoke with 20 staff members; including service leads, health visitors, community nurses and practice teachers
- reviewed 35 care records
- looked at a range of policies, procedures and documents related to the service

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

Outstanding practice

None identified for this focused inspection.

Areas for improvement

Action the provider **must** take to improve:

- The provider must notify the Care Quality Commission without delay of the death of a service user. **Regulation 16 of the Care Quality Commission (Registration) regulations**

Summary of this inspection

Action the provider **should** take to improve:

- The provider should consider reviewing the safeguarding children policy so that staff are clear of the provider's expectations.
- The provider should consider providing additional training to staff for non-mobile babies.
- The provider should ensure safeguarding supervision records time scales for action plans are documented.
- The provider should ensure that patient records are completed in a timely manner and up to date.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Requires Improvement	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Requires Improvement	Inspected but not rated

Community health services fo children, young people and families

Inspected but not rated

Safe	Inspected but not rated
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Requires Improvement

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

Inspected but not rated

We did not rate safe as the inspection focused on a few specific areas of the key question.

We found the following areas of good practice:

- Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff we spoke with knew how to raise a concern and follow-up a concern for non-mobile babies. Staff completed all levels of safeguarding children training and knew how to recognise and report abuse.
- Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.
- The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Incidents were reported appropriately, and we saw evidence that learning from incidents was discussed at regular staff meetings and safeguarding children update bulletins.

However, we found the following areas that the service needed to improve:

- Staff did not always complete comprehensive safeguarding supervision notes such as mandatory action plan dates. We reviewed 17 safeguarding records and found that three did not have a date by when identified actions had to be completed. This meant there was a risk that actions to address risks may be missed or not completed in a timely manner.
- All staff had access to an electronic records system that they could all update, but two of 35 records did not have up to date child protection information. One of these two records showed that the child was no longer under a child protection plan, which did not match with the records. The other record had a child protection flag missing from the child record. These were corrected by the team manager during the inspection. Staff did not always complete patient records in a timely manner. Three records, including the record of an unexpected death of a baby, had backdated entries although there was no indication that these were retrospective entries. Backdated entries ranged from four to 17 days.

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

Community health services fo children, young people and families

Inspected but not rated

Inspected but not rated

We did not rate effective as the inspection focused on a few specific areas of the key question.

We found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence-based practice. Interventions were those recommended by, and were delivered in line accordance with, the National Institute for Health and Care Excellence (NICE) guidance, for example, for faltering growth babies.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and development. One hundred per cent had completed an appraisal in the last 12 months. The service provided opportunities for staff to undertake a range of specialist training courses to enhance their role.
- All staff received three monthly safeguarding supervision. Safeguarding supervision provided staff the space to consider the impact of their decisions and actions on the safety and wellbeing of children, young people and adults. Staff told us that they found these supervision sessions helpful. Across children's services, the safeguarding supervision rate was consistently 100%. All staff we spoke to confirmed that they had received management supervision.
- All those responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care and communicated effectively with other agencies. Patient records reflected staff liaison with accident and emergency departments, local authorities and Multi Agency Risk Assessment Conferences. Domestic violence cases were shared with other agencies.

However, we found the following area that the service needed to improve:

- Seven of 15 health visitors and community nurses we spoke with told us that they would benefit from additional training for non-mobile babies to ensure they made informed decisions in different scenarios.

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

Inspected but not rated

We did not rate responsive as the inspection focused on a few specific areas of the key question.

We found the following areas of good practice:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The service held meetings with the local authority, police, schools, nurseries, and other health care providers, as necessary, when transferring care.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers. Care records we reviewed showed that staff support for families.
- Records showed that people could access the service when they needed it and received the right care in a timely way.

Community health services fo children, young people and families

Inspected but not rated

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint. Staff we spoke with were clear about the complaints process and how to support families to make complaints.

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

Requires Improvement

This inspection focused on specific areas of well-led. As we found a breach of regulation, we have limited the rating of this key question to Requires improvement.

We found the following areas that the service needed to improve:

- The service had not submitted required notifications, for example the death of a service user, to the Care Quality Commission, without delay. The service submitted a notification for the unexpected death of a baby in September 2020 two months after the baby died in July 2020. The provider recognised the need to ensure notifications were completed without delay and after the inspection introduced new processes to ensure this would happen. These would need time to become embedded in the service.
- The service safeguarding children's supervision policy was not clear especially for staff who were new to the role and not familiar with the organisation. For example, the policy stated that bank/agency staff could only access safeguarding supervision six monthly and only in group form, but in reality this was not the case. The head of health visiting Bromley clarified that bank and agency staff could access three monthly one to one supervision and were not limited to six monthly group supervision. In addition, the policy stated that the Bromley relationship model was used for safeguarding supervision, but the policy did not explain what this model entailed.

However, we found the following areas of good practice:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for children, young people, their families and staff especially during the COVID-19 pandemic.
- The service had governance arrangements that were well-developed and embedded. The service used audits to check on the quality of the service it provided. For example, the service had completed a domestic abuse audit to check if staff were asking routine questions at every contact. This audit found that health visitors asked about domestic abuse, which was documented clearly and accurately.
- The service had seen an increase in Multi-Agency Safeguarding Hub (MASH) referrals over the period of the pandemic. These were managed safely. The service completed audits to show the impact and risks of staff shortages and provided an additional member of staff to assist with referrals.
- Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

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
Treatment of disease, disorder or injury Diagnostic and screening procedures Family planning services Transport services, triage and medical advice provided remotely	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services