North Somerset Community Partnership Community Interest Company

1-293935970

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 29th November to 2nd December 2016
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-310911016	Castlewood	Services for children, young people and families	BS21 6FW

This report describes our judgement of the quality of care provided within this core service by North Somerset Community Partnership CIC. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by North Somerset community Partnership CIC and these are brought together to inform our overall judgement of North Somerset Community partnership CIC

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

We rated services for children, young people and families as good because:

- Senior managers were aware of the challenges the children's service faced and were taking steps to plan services in a way that would reduce risk to children and their families. They were using available information about the needs of families in their locality to plan services within financial limits.
- Staff were encouraged to contribute their ideas in how support was offered to families. This had resulted in different ways of working in order to engage vulnerable families.
- Most staff were trained appropriately and qualified for their role. They were knowledgeable about safeguarding procedures and received support to ensure their practice was current although a few unregistered support staff were not trained to the appropriate level for safeguarding children.
- There had been no reportable incidents requiring investigation within the previous 12 months. Staff followed the organisation's protocols for reporting incidents and were keen to learn and improve their practice. They assessed risk for children and their families and took appropriate action to minimise that risk.
- Multi disciplinary working was good and Staff worked with external agencies and disciplines within their organisation to support children and families and promote improved health outcomes.
- Care was provided using nationally recognised guidelines and standards. Activity and health outcomes were measured and results were shared with staff.
- Staff showed compassion and respect for children of all ages and their families and ensured their dignity was protected. Children and families were treated with sensitivity and supported to access health care. Some people needed additional support and staff provided this. Interpreters supported people whose first language was not English.
- Staff were aware of their responsibilities around consent and when to share information to benefit children, young people and their families.
- A reduction in funding for the Children's Service had created a risk of the organisation failing to meet performance indicators in delivering care to children and families. Managers had escalated this risk to the executive team and were working with commissioners and public health colleagues to identify the needs of the population. This would allow them to prioritise where care was needed most.
- Staff were encouraged to take opportunities for professional development and put learning into practice. Managers supported staff to analyse how they could work differently to make the service more efficient.

However:

- Some staff had very high caseloads of families with enhanced needs and regularly worked beyond their contracted hours to deliver a safe service.
- The school nursing service prioritised referrals to their service and non urgent referrals who wanted to see a school nurse had a four month wait.
- Themes from audits carried out in localities were not always clearly shared with staff.
- Record keeping systems caused duplication for staff who needed to use electronic and paper records together to make a complete patient record.
- Administration staff working in the No Worries service who had face to face contact with young people were trained at level 1 safeguarding. National guidance advises this should be at level 2
- The No Worries sexual health service was vulnerable due to lack of formal service agreements. There were no formal agreements with estates department for the use of clinic areas or with a local GP practice that supported a weekly clinic. There was also no formal agreement for the provision of clinical supervision for the lead nurse which was provided by a clinician from another service.

Summary of findings

- The No Worries service did not have a formal strategy for the development of the service over the term of the newly acquired contract.
- The identified risks within the No Worries service were not recorded on any form of risk register. There were clear lines of accountability and staff were clear about the reporting and management structures. However there was no indication that risks and service developments around the service were discussed at a senior or board level.

Summary of findings

Background to the service

Information about the service

North Somerset Community Partnership is a community interest company which has been registered with CQC to provide NHS funded community services since September 2011.

North Somerset Community Partnership CIC provides public health nursing services for all children aged between 0 and 19 years, who live in North Somerset. Children's services are made up of health visiting, looked after children, sexual health, immunisation, safeguarding and school nursing. The organisation provides population wide specialist diabetic nursing and bladder and bowel services who worked in partnership with the children's service. Staff use a variety of settings to deliver the heathy child programme and immunisation programmes and to help children to access more specialist support for health or emotional problems. They also work closely with external partners such as schools and social care colleagues to support children and families who may be at risk of experiencing abuse. Health Visiting teams provide care for children from birth to five years of age. They are based in six different locations across North Somerset and are made up of registered health visitors, young parent's team, nursery nurses, support workers and administration staff. Teams are linked with specific GP surgeries and see families in a variety of settings. This includes GP surgeries, health clinics, children's centres and patient's own homes.

The teams for school nursing, immunisation and looked after children are located in an office base in Weston Super Mare. They travel from this base to visit schools, clinics and patient homes in order to deliver the national healthy child programme.

- The School nursing team provides care for children who are of school age.
- The immunisation team arranges sessions to immunise school age children according to the United Kingdom national immunisation schedule for children.
- The looked after children team provides health support for 299 children from North Somerset. They work in partnership with health visiting and school nursing colleagues and liaise closely with social workers and foster carers. Senior managers had reviewed looked after children team staffing following the retirement of a named nurse. This resulted in additional staff hours with the recruitment of a designated nurse for half a whole time equivalent and an additional whole time equivalent specialist nurse role. Two part time specialist nurses made up the whole time role but services remained challenged due to unavoidable staff absences. The designated nurse took steps to ensure risks to looked after children were reduced. The designated nurse role is funded to provide services for the clinical commissioning group for half of the full time role.
- Diabetic and bladder and bowel specialist nurses were part of the team which provided support to whole age population. They work in partnership with children's service staff and set up pathways of care. They provide staff training, hold clinics, support children, families, children's centres, nurseries and schools on an individual basis.

North Somerset Community Partnership run sexual health services in the county which are known as 'No Worries'. The service provides a confidential clinic and which is open to all young people aged up to 21 years. The service provides advice on methods of contraception, chlamydia screening, pregnancy testing, and treatment for some sexually transmitted infections, and provides distribution for C-cards. The C card scheme enables first time registrants and subsequent users of the scheme to collect free condoms.

The service is staffed by two nurses with support from administration staff who also worked for the school nursing service. The service was commissioned as a level one service with the capacity to provide some elements of a level two service such as the fitting and removing of certain contraceptive devices. The service also has a role in signposting young people to level three services if required.

Summary of findings

Clinics were being run at health centres in Nailsea and Worle. A further clinic was run under the No Worries name, but staffed by a different provider, at a health centre in Weston Super-Mare. Clinics had previously been run in a local college but these were not happening at the time of the inspection. Patients can self-refer by telephone or make an appointment through their GP or be referred by other health professionals. Patients were also seen if they walked into a clinic and arranged to see a nurse. Outreach work is also provided, with one nurse available to meet with young people in the community.

During our inspection we spoke with children, parents, observed care being delivered in homes, clinics and in schools. This was all with consent of the patient. We gained views of staff members, and reviewed patient records.

Our inspection team

Our inspection team was led by:

Chair: Graham Nice**,** Managing Director, independent healthcare management consultancy

Team Leader: Tracey Halladay, Care Quality Commission

The team included CQC inspectors and a variety of specialists. These included specialist practitioners in health visiting, community nursing, safeguarding and School Nursing

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 29th November and 2nd of December 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, administration support staff, nursery nurses and specialist nursing staff. We talked with people who use services including children young people and their parents. This was at clinic attendances, parent information evenings, in schools, parent's homes and at education days for teaching staff. We spoke with 56 staff members which included nursing staff, administration staff, managers and senior executives. We also observed care provided at clinics, information sessions held for parents, spoke with 14 parents, 4 children and school staff who were supported by the service. We reviewed twelve patient records.

Summary of findings

What people who use the provider say

Parents we spoke with told us they were made to feel welcome when they attended any clinic or group sessions. Parents felt they were treated with respect and listened to by the professionals and felt staff supported their privacy. They felt confident about attending clinics and that it was a space where they could meet friends and peers. Children, young people and their families were spoken to in appropriate terms and were able to understand the advice given to them about options of care. Parents thought the service was helpful and staff supported them without being judgemental. Children, young people and their families knew how to access services if they needed it and trusted the advice given to them which reassured them about what actions to take if they had any concerns.

School staff were positive about the support they received from the school nursing service and were able to contact staff for support when they needed it. Young people we spoke with felt they had their questions answered when they attended clinics.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure there are sufficient numbers of staff to meet the needs of children, young people and families in all areas of North Somerset.

Action the provider SHOULD take to improve

- Consider how to ensure children's service staff receive feedback of themes and learning points from audits.
- Consider how to support health visiting and school nursing staff to have access to all relevant health information for children they see and reduce duplication of record keeping.
- Consider reviewing the need for formal service level agreements in relation to the provision of premises to provide No Worries clinics.
- Ensure provision of clinical supervision of No Worries staff is through a formal agreement when provided by other organisations.
- Consider how risks for the No Worries service are recorded as part of a service risk register.
- Consider developing a formal strategy for the development of the No Worries service.
- Ensure that staff who have face to face contact with young people are trained to safeguarding level 2 in line with national guidance.

North Somerset Community Partnership Community Interest Company

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Some health visitor teams had larger caseloads than national guidelines advised. Managers did not know how many school nursing staff were needed for the needs of the population. However, managers were undertaking work in preparation for using an acuity measurement tool in the near future. This was to ensure that information about population needs was accurate and would provide appropriate advice about staffing levels.
- Record keeping systems created duplication for staff although plans were in place to roll out an electronic record keeping system in the near future.
- Administration staff working in the No Worries service who had face to face contact with young people were trained at level one safeguarding where national guidance advises this should be at level two.
- Mobile technology was being used to a limited degree. Mobile phones had variable connectivity and electronic records could only be accessed at the office base.

However:

- Staff used established systems to report incidents and concerns. There had been no serious incidents that required investigation during the previous 12 months.
- Staff were open and honest and keen to learn from incidents that had been reported.
- They ensured that children and their parents knew how to complain if they needed to.

Requires improvement

Are services safe?

- Safeguarding policies were based on national guidelines and registered nursing staff in all areas of the children's service were compliant with these policies. Staff ensured they followed the organisation's protocols to maintain good hygiene standards for infection prevention and control.
- Most staff had attended mandatory training and were aware of what subjects they needed to complete.
- Assessment of risk for children, young people and their families was carried out and staff took appropriate action to minimise it. School nursing staff ensured medicines for vaccinations were ordered, stored and administered safely.

Incident reporting, learning and improvement

- Incidents were monitored and staff followed the organisation's policies to report them. This allowed the incidents to be investigated and learning to be shared across the organisation. There were no serious incidents requiring investigation involving the children's services, reported between November 2015 and September 2016. Staff found the system easy to use and received feedback usually within 48 hours. Some of the incidents reported had included when staff had not been invited to child protection conferences by local authority colleagues. This information had been shared with social care and the communication about child protection conferences had improved.
- Staff working in the No Worries service were aware of how to report incidents and their responsibility to do so. During the twelve months prior to the inspection there had been no notifiable incidents in relation to clinical issues. All the incidents report had related to environmental or equipment problems.
- Feedback was usually provided to reported incidents where this was appropriate and the lead nurse heard feedback from incidents reported by the school nursing service when they attended the joint management meetings. We saw documented discussions about an incident where a professional inadvertently shared patient information. The professional had an action to apologise to the client and inform them of the process to make a formal complaint. Learning from this incident was shared at team meetings.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. The organisation incorporated duty of candour principles into the mandatory training for all disciplines.
- The nursing staff who worked in the No Worries service were aware of the Duty of Candour legislation and its requirements. Training had been completed by the lead nurse. The provider had run managers training in September and October 2015. Figures showed that 70% of North Somerset Partnership staff had been trained at the end of December 2015.

Safeguarding

- Policies for safeguarding children followed national recommendations and processes from Working Together to Safeguard Children and were embedded within the workforce. A team of senior staff and executives had responsibility for safeguarding children, young people and their families. Health visiting and school nursing staff worked with partner agencies, such as, social workers, schools, children's centre staff and commissioners to identify children and families who need further support. A joint adult and children's safeguarding group met three monthly to monitor safeguarding processes, share national and local learning and identify where improvements could be made. The safeguarding team provided training for all staff in the organisation which they called 'Think Family'. This was attended by staff from any discipline, adult or children's services and incorporated level two safeguarding children training.
- Registered nursing staff and nursery nurses attended safeguarding children training to the appropriate level for their roles, which followed national guidelines from Safeguarding Children and Young People: Roles and Competences for Health Care Staff, Intercollegiate Document, March 2014. Training figures for September 2016 showed level two training had been attended by 93% of staff and level three training had been attended

by 97% of staff. Staff were able to describe what would alert them to concerns for a child and how they would report this to the organisation's safeguarding leads and the local authority for social care input.

- All children's service staff were supported to identify safeguarding concerns and actions they could take to help to keep children free from abuse. Supervision was provided every four months for individual staff. Supervisors had received additional training in supervision practices. These discussions were documented in the child's record and copies were held by the supervisor and practitioner for their reference. Staff found the supervision process helpful and said they could access support from the safeguarding team any time they needed it.
- The electronic record keeping system had alerts built which we saw highlighted safeguarding concerns and children who were on a child protection plan to any professional who accessed the record. Paper records had a sheet at the front of the record which highlighted any safeguarding concerns. This ensured that professionals could plan care appropriately for the needs of the child and family.
- Learning from external agencies and nationally reported cases was shared with all children's service staff. Serious case reviews were attended by safeguarding leads and learning from these cases were shared using newsletters, at supervision and at team meetings. One of the messages was for professionals to consider the family as a whole when assessing children's needs. This prompted them to ask the question "how are the needs and behaviour of the individual service user impacting on other members of the family?"
- Safeguarding and health visiting staff were working with the local authority on a method of sharing information and providing early help for children. Separate electronic systems were causing difficulties but health visiting staff were able to refer children to children's centres for support.
- Safeguarding training at level three was completed by clinicians working within the sexual health service. Administration staff completed safeguarding level one training and also child sexual exploitation (CSE) training. However staff who have direct face to face contact with young people should, according to national guidance, be trained to level two. All staff working in the service had completed training on female genital mutilation (FGM) child sex exploitation (CSE) and trafficking of young people. Staff were provided with policies and procedures regarding the safeguarding of vulnerable adults and children.
- Communication processes between agencies were established to support vulnerable children. The local authority social care team invited school nursing and health visiting staff to early strategy meetings to discuss any safeguarding actions that were necessary to protect the child.
- Staff were aware of how to contact the safeguarding team and how to access further advice if this was required.
- Staff we spoke with demonstrated their level of understanding of safeguarding processes and procedures. We observed a discussion between staff relating to a recently seen young person. We saw that all areas were considered and recorded and the action to be taken was carefully considered.
- Staff had attended child protection multi-agency meetings when requested or necessary.
- The lone working policy was followed by staff who were supported by their colleagues and managers. A paper record of visits was kept at the base. Health visiting staff informed colleagues of any visits that were risky and telephoned when it had been completed.

Medicines

- Health visiting and school nursing staff used safe practices for the delivery, storage and administration of medicines, which was in line with legislation. Medicines were ordered by school nursing staff to provide immunisations for cohorts of children in schools. We saw these medicines were stored and transported at correct temperatures. Staff checked and documented expiry dates and fridge temperatures where medicines were stored which followed the organisation's protocol. School nursing staff could describe actions they needed to take if temperatures were outside of prescribed temperatures but had not had reason to report this previously. Portable electric cool boxes that could be powered by a socket in the car were used to transport

medicines at the correct temperature. These boxes had been recently purchased and provided a more consistent temperature than freezer blocks that were previously used.

- Nursing staff received training on immunisation processes each year and worked to a protocol of using Patient Group Directions (PGD). The PGD is a process that authorises appropriate professionals to administer prescription only medicines to patients without needing an individual prescription for each child.
- The lead nurse for the No Worries service had additional qualifications which enabled them to be a non-medical prescriber. This meant they were able to prescribe and administer certain medicines without a doctor present. Other nurses were able to supply specific medicines to patients without the need for a prescription as directed within written PGDs. We looked at a sample of these and saw all were ratified within the recorded sign off date by the appropriate authority.
- Medicines were transported and delivered by staff from the main office to the clinic which was not staffed by the provider. We observed on one occasion that these were not transported in a secure tamper-proof container as required by regulations. We were subsequently told that the policy was that medicines were transported in tamper-proof containers with codes known only to the staff. We did not see the storage facility for these medicines but the nurse who ran this clinic explained they were stored separately from the other medicines in the practice and that all unused medicines were returned to the main No Worries office. Medicines were booked in and out of the No Worries office by the lead nurse.
- We saw that the medicines were stored securely in the health centre clinic in Nailsea that we visited.
- Medication audits were completed monthly by the lead nurse. We saw that the previous three months had been completed satisfactorily with no identified issues or concerns.

Environment and equipment

- All areas we visited were safe and appropriate for their purpose. There were adjacent waiting areas with seats and toys available for young children. We saw cleaning schedules which documented any toys used had been sanitised appropriately. School nursing and health visiting staff were able to take equipment that was necessary for their activity in a school or alternative location. This included emergency equipment in case a child reacted to an immunisation, bins to dispose of needles and other sharp items. Any waste was transported to a health clinic in line with the organisation's policy. This ensured that clinical waste could be stored and disposed of safely. The sharps bins we saw were labelled and signed according to the organisation's protocol.
- Equipment was documented as maintained and ready for use. For example, weighing scales were documented as calibrated annually and we saw emergency equipment had been checked by staff as in date and safe to use.
- In the No Worries clinics the staff had access to and were aware of the location of resuscitation equipment. This equipment was provided by and maintained by the agency providing the clinic space. There were no specific assurances in place around the maintenance of this equipment as there was no service level agreement in place for the use of the premises.
- The lead nurse for the No Worries service had completed environmental risk assessments on the clinic areas which delivered the service. We saw these had been completed and regularly reviewed.

Quality of records

- Children's records were kept securely and maintained confidentiality. There was a system of keeping records both in electronic and paper format. These needed to be used in tandem to provide a complete record. Paper records contained an overview of the care provided and a chronology of significant events. Details of visits and ongoing care needs were documented in the electronic record. The electronic record could only be accessed at the health visitor base. Staff told us they made informal notes at the visit to ensure they remembered details of the visit and completed paper and electronic records at their office base as soon after the visit or consultation as possible. Records we saw were legible and displayed actions that were taken and the ongoing plan of care. Entries were signed, dated and timed. There was some duplication in this system as staff needed to make informal notes before and after a visit to ensure they

had all relevant information. Managers informed us of plans to move to a completely electronic record keeping system and were aware that present arrangements were not ideal.

- Quality of records was monitored using a system of audit by colleagues. Staff had a regular number of records to review each month, using an audit tool which observed a number of items including patient history, examination results, details of care, consent to assess or treat the child and information given to the patient. Health visiting teams had achieved 92% compliance with the organisation's record keeping standards in the quarter from April to June 2016. These results were reported to managers and staff told us they were informed by their peer auditor of any improvements needed but did not receive any feedback from managers regarding the overall results or themes. We looked at eight sets of patient records and most were accurately documented. Two of these had some details missing for example a nurse had provided support but not documented this and a care plan had not been updated.
- The No Worries service had its own confidentiality policy as part of the wider organisation policy. This related to the availability of access to the information on a young persons file. The electronic record system controlled the level of access a person looking at the records could have. The records in the service were audited on an annual basis and no issues had been found at the most recent.
- We looked at a sample of four files from the No Worries service and found they were contemporaneous, signed and dated where required. We saw that discussions were documented and relevant details relating to family history or social context were also recorded.

Cleanliness, infection control and hygiene

- Staff followed the organisation's protocols for infection prevention and control. An audit from October 2016 had shown Children's service staff were 95% compliant with the organisation's policy on hand hygiene technique.
- Equipment including weighing scales and toys were cleaned after use and between patients.
- Teams were represented by staff at infection prevention and control meetings. Information was then shared at team meetings. As an example, school nursing staff were informed of a change in frequency of hand hygiene technique audits from six monthly to annually. The decision had been made by the specialist infection prevention and control team because there was an audit between annual mandatory training sessions. This ensured observation of hand hygiene practise occurred on a regular basis. Posters displaying good hand washing techniques which were displayed in each of the premises we visited acted as reminders to staff.
- We observed staff displaying good hand washing techniques between contact with babies and children.
- School nursing staff carried personal infection control packs with them. This was for use when there were no hand washing facilities easily available in a location they were visiting. The packs contained liquid soap, hand sanitising gel, paper towels and gloves.
- School nursing staff were informed of any school which was experiencing an outbreak of communicable disease. A member of the school nursing team would attend the school to provide hand washing sessions and information on how to control infection, for the pupils.
- Staff working in the No Worries service had completed, and were up to date, with their infection control training. We observed good procedures being followed in the clinics we attended. They did not have a responsibility to complete audits in the clinic areas they used but were aware of how to report any concerns they had. Staff told us that the clinic areas were always clean and hygienic and ready for use when they arrived.

Mandatory training

- The organisation supported staff to attend mandatory training to ensure staff were up to date with essential safety skills for their roles. This included subjects such as health and safety, infection prevention and control, basic life support for children, manual handling, prevent training and information governance.
- Staff compliance with mandatory training was targeted at 90% and in most cases this was achieved. This was monitored by managers and reported to the organisation's board members on a quarterly basis. Staff told us they were informed of their training needs at meetings with their manager. Children's service staff attendance at mandatory training ranged from 85% for

safeguarding children level one (non-clinical) and 100% for manual handling and 'prevent' training. The majority of subjects in mandatory training had been completed by 93% of staff.

- The two nurses employed within the No Worries service and the administration staff that supported the service were all up to date with their required mandatory training. Training was checked as part of the annual appraisal process.

Assessing and responding to patient risk

- Risks to children were assessed by staff and advice was offered to parents on how to access further support. The children's service was not an emergency service and parents were given information on how to access further support for their child.
- Children and young people with emotional and mental health problems were supported by partner agencies. School nursing and health visiting staff could refer a child to this service and receive immediate advice from the Child and Adolescent Mental Health Service (CAMHS) on how to support the child.
- Urgent medical examinations for child protection cases were provided by another organisation. Staff told us they had effective links with the service and the medical examinations were usually performed within 24 hours of the request.
- School nursing staff supported all schools with medical issues including schools for children who had complex needs. They provided training for school staff on how to manage medical conditions including asthma, anaphylaxis, epilepsy and any other condition the school needed support with.
- Sexual health risk assessments were completed on all young people aged under 16. People were always asked if there were any other professionals working with them or their families. This information was recorded within the patient files.

Staffing levels and caseload

- The organisation had reached the required number of health visitors stipulated in the Department of Health National Health Visitor Plan 2011-2015, by December 2015. However a reduction in funding from public health had meant that health visitor staff numbers had reduced from 43 to 39 whole time staff in September 2016. The impact of this was a risk that staff would not be able to meet the contact points recommended in the national healthy child programme. The Community Practitioners and Health Visitors Association (CPHVA) recommend caseloads for health visitors should be a maximum of 400 in the least deprived 30% of the population. Caseloads varied across North Somerset from 1,881 to 4,890 per base. Caseloads were shared between the locality team but if they were shared per health visitor there would be 468 children allocated to each health visitor and 68 of these children would need additional support. Health visitors at the Weston Super Mare base received safeguarding supervision for more than 30 children on each of their caseloads which was a higher number than the other four bases. Numbers and acuity of caseloads were monitored by managers but no acuity tool was used. This was because acuity and data collection were being reviewed with a plan to reintroduce a nationally available acuity tool for health visiting services early in 2017.
- Managers of the health visiting and school nursing had stopped using a staffing tool to assess how many staff were needed to meet the needs of children and families in North Somerset. This was because information collected on the electronic system about acuity of the families did not match information health visiting staff held on a manual system. Managers were in the process of matching the data gathered electronically and manually to ensure the electronic system would gather precise data before they introduced an alternative tool to assess what staff numbers should be to effectively meet the needs of the population.
- Nursery nurses were allocated to each base and undertook activities to support the work of health visiting teams. For example, child developmental assessments and supported parents with breastfeeding.
- Staff worked across the organisation within their teams and were able to cover any planned annual leave. Staff told us there were no bank staff to use if there was an unexpected staff absence. Staff would reorganise their caseloads to prioritise the most vulnerable families and postpone appointments that were more routine. However, the provider subsequently informed us a member of bank staff was available and there was a recruitment drive to increase bank staff numbers.

Requires improvement

Are services safe?

- Paediatric specialist doctors were not employed by the organisation. Any specialist advice was provided by partner organisations and referrals were made by following identified clinical pathways.
- School nursing numbers did not meet staffing levels recommended by the Royal College of Nursing. Numbers of school nursing staff was based on the budget provided by commissioners. The lead for the service reviewed staffing needs when a post became available. As an example, there was a change in the looked after children service when a member of staff retired and commissioning arrangements were altered. Staffing was reorganised to join together school nursing and children looked after roles which increased the actual staff numbers.
- The No Worries service had sufficient staffing to manage the workload. The service ran a maximum of 17 clinics per month. From September 2016 this had reduced to 12 per month as they were unable to run a clinic in a local college due to a lack of space. The outreach service had an active caseload of 35 young people at the time of the inspection.
- The provider had recorded a 14% staff turnover overall in the previous twelve months and a 4% sickness rate. The No Worries service had no turnover of staff during this period and there were currently no vacancies.

Managing anticipated risks

- Practitioners assessed the risk of visiting homes using information from colleagues and other agencies. Staff told us, if there was a history of aggression in the family, they performed joint visits with colleagues or encouraged parents to attend clinics instead of having home visits. They recorded risks in the child record to ensure the information was available for colleagues who may perform subsequent visits. We saw there was an area on the child record for this information.
- Any risks to the running of the business were identified in the organisation business continuity policy. Managers were to monitor risk according to the time of year. For example, heat waves in summer and snow in winter. Managers would cascade alerts of perceived risk to staff, such as weather forecasts, which would allow staff to advise their families on appropriate safety actions in the event of flood or heatwave. Other actions for staff to take in the event of severe bad weather included assessing the needs of their children and families, rearranging non essential visits, using health bases close to staff homes and using telephones and technology to provide support for families
- Provision had been made to support the No Worries staff to manage any potential risks associated with contact with young people in the clinical areas. In the clinic rooms used by the No Worries team alarm buttons were located for staff to use in an emergency. The staff we spoke with were familiar with the provider's lone working policy and able to explain how they followed this. All the staff, including the administration team, had completed a "managing conflict" training course.
- We identified there were a number of potential risks to the continuity of the No Worries service due to the lack of service level agreements. These included:
  - One of the No Worries clinics was run from a health centre run by another provider. This clinic was run for two hours every week by a nurse not employed by North Somerset Community Partnership and they coordinated and liaised with the lead nurse for the No Worries service. There were also potential risks associated with a lack of clarity over accountability and the reporting of incidents and any subsequent learning.
  - The lead nurse received clinical supervision from a clinician working for a local acute trust; however there was no formal agreement in place for this arrangement.
  - There were no cover arrangements for the No Worries service for sickness or annual leave. During these times clinics did not run and a phone message advised callers the service was unavailable. Information was given about alternative sources of information.
  - The service had been running a weekly clinic in a local college but at the start of the September term in 2016 they were told the rooms were no longer available and the clinic had been stopped. It was unclear whether this would be started again. There was no service agreement in place with the college which meant the renegotiating of the reintroduction

of service was difficult. This meant that young people did not have access to a clinic during normal college hours and would have to locate a service in the community.

Major incident awareness and training

- Business continuity plans had been developed and were in place. These detailed levels and types of risk to service delivery and the actions managers and staff should take. Health visiting and school nursing teams had plans, which were specific to their service, for when and how to escalate concerns when there was a disruption to the service. It included detailed actions to be taken based on how long a disruption would last and specified identifying vulnerable people and how to ensure they received the care they needed as well as safety for staff. Staff were aware of these plans and knew how to access the information on their organisation intranet.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as good because:

- Audits were undertaken to measure how well the service was performing and where improvement was needed. These results were shared with senior executives and staff.
- Staff were qualified for their roles and encouraged to access opportunities for professional development which they applied in their work with children, young people and families.
- Health promotion activities were measured for positive outcomes and showed breast feeding figures at six weeks after birth were better than the national average.
- Immunisation uptake for school age children was good. The flu immunisation rate was at the higher end of the national target range for 2015/16.
- There was evidence of good multi-disciplinary working across all teams.
- All staff we spoke with were clear about their responsibilities to gain appropriate consent and when they needed to share information with other agencies.
- The No Worries team had good access and positive working relations with other professional teams, including school nurses, local GPs, social care and safeguarding. In the No Worries service there were clear pathways to be followed for the referral to other services when this was as required if the need of the young person was outside of the remit of the service.

However:

- Health visiting teams provided care as agreed with commissioners. However, this did not always follow national guidance and could have an impact on the health outcomes for children and young people.
- The No Worries service was small and collected relatively limited amounts of outcome data.
- The No Worries service was commissioned as a level one service and meetings were held with the commissioners but the service specification had limited detail. The size of the service, and the level of service and the frequency and location of clinics did not appear to be based on an evaluation of the needs of the population it served.
- There was also no formal agreement for the provision of clinical supervision for the lead nurse which was provided by a clinician from another service.

Evidence based care and treatment

- National evidence and guidelines were used to deliver care and treatment and plan services. However, staff were not always able to provide visits according to these guidelines and managers were discussing these concerns with public health colleagues. Health visiting and school nursing staff provided assessments and support for children by following the Healthy Child Programme. This is a Department of Health programme of key points in a child's life where assessment and intervention have been evidenced to help children achieve better health outcomes. This includes contacts with expectant mothers, assessments of their baby's growth and development, childhood measurements for school children and immunisations. Health visiting staff reported their contacts with mothers and babies at five key points in development: antenatal, within 14 days after discharge from midwife, six to eight weeks after birth, 12 to 15 months of age and two to two and a half years of age. We saw performance reports which identified the number of contacts made at these key points did not meet the 90% target. For example, for the quarter July to September 2016, staff had performed 54% of required antenatal visits and 62% of planned visits within six to eight weeks of birth. For a period of time prior to September 2016 both visits had been a targeted service only to families with identified vulnerabilities. This had been agreed with commissioners. Since this time they had been reinstated as a 'universal' visit to all mothers and babies which was compliant with national guidance. The impact of the change meant that health visitors were required to perform more visits in total and some health

visiting staff had been unable to meet the targets. Data was available for each health visiting team. Staff at the Weston Super Mare base told us their high safeguarding levels meant they were unable to meet the organisation's target for each of the five universal contact points with all new parents.

- National Institute of Health and Clinical Excellence guidelines were assessed for relevance by professional leads for the service and compliance with these were monitored by senior managers and executives. For example CG189 Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (Issued November 2014). This baseline assessment was presented at of the board meeting in February 2016 and was under review by all areas before an assessment could be made of actions needed. Paediatric diabetic specialist nurses followed Nice Guidance - Diabetes (type 1 and type 2) in children and young people: diagnosis and management (NG 18; updated November 2016).
- Health visiting staff provided support for mothers with breast feeding and had achieved UNICEF baby friendly level three accreditation. This allowed new mothers to make informed choices about how to feed their baby.
- Children who were looked after by adults other than their own parents (looked after children) were supported according to national guidelines in Promoting the Health and Wellbeing of Looked After Children. A designated nurse for looked after children monitored the quality and timeliness of completed health assessments. These had a target of all children having health assessments completed every six months if they were aged under five years and every 12 months if aged over five years. This was to ensure their health needs were identified and actions shared with their social workers and foster carers. Performance for these health assessments met the target. The looked after children designated nurse carried out an audit in October 2016, with actions for improvement identified. This included providing individual support for professionals who completed review health assessments to ensure they were of good quality. The designated nurse attended support meetings with other designated looked after children nurses in the South West. This was to support best practice and followed national guidelines.
- Safeguarding procedures followed recommendations in the document Working Together to Safeguard Children 2015. All staff were aware of recognising signs that would suggest children might be at risk of harm or abuse.
- No Worries staff were knowledgeable about guidelines and recommendations provided by the various national bodies including the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH). Clinical guidelines produced by the National Institute of Health and Care Excellence (NICE) were followed.
- The service contributed to the national chlamydia screening programme and staff were aware of and operated within the standards provided by the national programme.
- The staff were provided with and working to the service's pregnancy testing standards which had a review date of September 2017. These included Fraser and Bichard guidelines checklists. These guidelines provide guidance to professionals over advice and treatment and confidentiality when working with young people under the age of 16 years. There was also a pregnancy testing competency check list.

Technology and telemedicine

- Technology was being used to support delivery of an effective service to a limited degree.
- The electronic record keeping system was limited in use and had been found to be inaccurate in collecting data. Managers were completing a programme of work to ensure electronic data collection could be accurately recorded by nursing staff. It could be used for maintaining records at office bases on desk top computers and needed to be used in conjunction with the paper record in order for it to be a complete record. The organisation had plans to roll out mobile working devices but Children's Services had not received this equipment at the time of our visit.

Patient outcomes

- Outcomes of interventions for children, young people and families were monitored and information contributed to national audits.

Good

Are services effective?

- Health visiting staff collected data about numbers of mothers who were breastfeeding their babies. This contributed to national audit for breastfeeding and was compared with rates for other areas in England. The percentage of mothers still breast feeding their infant at six to weeks of age was between 51% and 53% over the 12 months from April 2015 to March 2016. This was better than the national average of 42%.
- School nursing staff undertook school entry screening for children and took part in the national child measurement programme by measuring children's height and weight at school entry and year six. The information was anonymised and contributed to national figures. It was also used locally to offer support for those children who were either overweight or underweight for their height.
- The school age immunisation programme was being administered by North Somerset Community Partnership. This included immunisations against diphtheria, tetanus, polio and ACWY strains of meningitis. Uptake for children in school year 9 meningitis immunisation was 80% for 2016 which was slightly worse than the England average of 84%.
- Immunisation against flu had been provided by an alternative organisation until September 2016. After this time North Somerset Community Partnership had been providing flu immunisations for school age children. Uptake of the flu immunisations in school years one, two and three had increased from 54% in November 2015 to 67% in November 2016. This was at the higher end of the national target range of 40 to 65% for 2015/16.
- A smoking cessation programme was delivered by the health visiting service. Success rates used national measures to determine activity outcomes. For example, the number of people who set a quit smoking date and remained non-smoking four weeks after that date. These results were placed into categories of average, good and excellent. North Somerset Community Partnership had remained in the good range of 30-40% for all of 2015 and for the first nine months of 2016. The health visiting service used these figures as motivation to improve their quit rates from good to excellent and were piloting a revised service.
- The service used figures collected by partner agencies to indicate the effectiveness of interventions. Health visitors used a variety of methods to support gipsy and traveller families. Staff told us they measured their success by the number of children from these families, who attended baby clinics and went on to attend local schools and nurseries. At the time of our visit staff told us that all children who were eligible to be in school were attending.
- The No Worries service had all the information about face to face contacts with young people recorded on a monthly scorecard as part of the school nursing service data. This provided information about the number of clinics run, the number of attendees and the reason for the appointment. They also recorded the number of outreach appointments that had been undertaken. Due to the level of service being provided there was limited patient outcomes that could be recorded.

Competent staff

- The organisation ensured their staff were competent to undertake their roles by providing training opportunities, clinical support and monitoring professional development.
- Staff were qualified for their roles and many had additional training in their area of expertise. For example Health Visitors and band six School Nurses had completed the Specialist Community Public Health Nursing degree. Band five registered nurses, support staff and administration staff also worked in the school nursing team under the supervision of band sixes. Health visitors were supported by nursery nurses and support assistants. Support staff were able to accept referrals to the school nursing service and ensure they were triaged by a registered nurse. Nursery nurses were trained to undertake development checks for children up to five years of age.
- All staff undertook training of continual professional development to ensure they were competent in their area. Newly registered staff were supported in the first six months of their role with a preceptorship programme. This provided enhanced supervision and training to ensure they were able to practice safely and with confidence. All staff we spoke with knew what their role was and when to seek support from more experienced colleagues. Staff were also supported in

their teams and practice was monitored at allocation meetings where staff could ask for further support if they needed it. Practice educators supported the learning and development of staff in school nursing and health visiting.

- Staff appraisals were provided for annually for all health visiting and school nursing staff and identified where training was needed to provided further professional development. Personal development reviews were monitored and for the period January to March 2016 92% of staff were up to date. This met the organisation's target of 90%.
- We were told of a leadership programme that some staff had attended and projects they developed as a direct result. These projects supported vulnerable families and included support to gipsy and traveller families and smoking cessation support for expectant and new mothers.
- Staff we spoke with told us how they accessed training to improve care for people on their caseloads. We were told of how a member of health visiting staff had requested and supported to attend a 'train the trainer' course for feeding and nutrition in children. A meeting had been organised with public health colleagues to plan how to roll out further training for Children's Services.
- Each member of staff was supported by a manager with one to one meetings held six weekly as a form of clinical supervision that supported ongoing reflection and monitoring of their practice.
- The nursing staff and the administration staff working in the No Worries service had all completed annual appraisals within the previous twelve months. All nursing staff were up to date with their professional revalidation. Staff told us that at times they felt unsupported by the organisation in relation to maintaining their competencies due to a lack of funding and a lack of capacity within the service to provide cover when staff were on training courses. The lead nurse was working toward a Faculty of Sexual and Reproductive Healthcare (FSRH) diploma.
- Cascaded training around sexual health issues was provided to the school nursing team by the lead nurse from No Worries.

Multi-disciplinary working and coordinated care pathways

- Staff worked in partnership with many agencies to provide children with opportunities for support with health needs. Children of school age could be referred by school staff, GPs, social workers, parents and could refer themselves. They were seen at reception health reviews, child measurement programmes. Health visiting staff liaised with midwives, GPs and social workers, children's centres and early years support staff. They held clinics, visited families at home and used the Healthy Child Programme to provide support for families.
- Children's needs were discussed at health visitor allocation meetings. This included routine planned contact and any additional referrals. Children who were referred to the school nursing service had their needs assessed by a registered member of staff and were allocated to the most appropriate member of the school nursing team. This could be staff who had a special interest or additional training in for example, mental health or sexual health. We saw how a health visiting team were informed by social care of a child at risk from their area and the date of a strategy meeting to discuss actions needed. Arrangements were made for a member of staff to attend.
- The diabetic specialist nurse was pro-active in identifying children with diabetes who needed support by contacting local children's hospital wards to find out about children who had been admitted with diabetes. Any agencies involved with the child were contacted by the diabetic specialist nurse and offered appropriate support to help the child cope with their condition.
- Health visiting staff were collaborating with social care regarding the design of a template which could be shared between the organisations to deliver early years support. This was proving to be a challenge due to the different electronic record keeping systems the organisations were using. Information was shared with children's centres who offered much of the early years support.
- Staff were supported by specialists to offer initial care. For example, CAMHS staff provided group supervision

for school nursing staff every two months, were accessible by phone between times and the bladder and bowel service were available for support and advice throughout the working week.

- There was a clear strategy for which public health nursing team was responsible for a child's health care. Health visiting staff were the lead public health nursing staff for children before they began school and school nursing staff took this responsibility when children progressed to school.
- The No Worries team had good access and positive working relations with other professional teams, including school nurses, local GPs, social care and safeguarding. Staff attending a number of multi-disciplinary meetings and we were told the communication between professionals worked well. Staff attended the areas multi-professional young people's forum that met monthly and also a teenage pregnancy meeting with midwifes and outreach nurses which covered a wide locality.
- In the No Worries service there were clear pathways to be followed for the referral to other services when this was as required, if the need of the young person was outside of the remit of the service. For example there were pathways for termination of pregnancy, referrals to young people's mental health services and for young people who may have been the victim of sexual assault there was a clinical pathway to a Sexual Health Referral Centre (SARC). A pathway for teenage pregnancy was in place titled "I think I might be pregnant". All professionals who participated in pregnancy testing had access to a copy of this pathway which included full details of a range of local provision, for example support available within and outside of the education system.
- There were also health and well-being pathway that could lead to referrals to counselling and advice services.

Referral, transfer, discharge and transition

- Staff worked together to assess and plan care for children and young people. Health visiting staff held allocation meetings every week to prioritise and allocate visits including new birth visits, referrals from midwives and GPs and any safeguarding issues.
- Families were supported at times of transition from one service to another. For example, health visiting staff attended meetings with midwives to ensure they were aware of the ongoing needs of families and provided school nursing staff with information about children who were about to start school. School nursing staff received a paper template and met with health visitors in person to develop care plans. Parents were informed of the school nursing service by attending parent's evenings for children about to start school. This included information about school entry health questionnaires and how to contact a school nurse.
- Diabetic specialist nursing staff supported children and young people to move into adult services by attending transition clinics. GPs received information from children's service staff about ongoing needs patients registered at their surgery.
- School nursing staff received notifications of children who attended the emergency department to ensure children were supported and safeguarding issues were followed up appropriately.
- All children's service staff could refer children to other agencies for further support using agreed pathways of care. This included referral to the bladder and bowel service, community paediatric consultants, social care and Child and Adolescent Mental Health Services (CAMHS). Children were placed on a waiting list for the service, which for the bladder and bowel service was four months. Children continued to be supported by school nurses if they needed to wait to be seen by CAMHS.
- Looked after children were supported by looked after children's nurses when they were about to leave care. Support was provided by liaison with the social worker for these children who would offer care leavers contact with health professionals.
- The No Worries was primarily a self referral service though young people could be advised and encouraged to visit the service by their GPs or other health professionals.

Access to information

- Staff had access to up to date information regarding the care of children they were visiting. Paper and electronic records were completed for each child and visits with

ongoing plans of care were recorded for relevant staff to view. Electronic records were only available to view at health visitor bases but staff could carry paper records for reference. We saw staff referring to electronic and paper records before visiting children and completing the systems following a visit. Staff needed to complete both sets of records in order for the child record to be complete and we were told this caused some duplication in their practice.

- Staff followed the organisation's information sharing policy when children moved between services and in or out of the area. Staff showed us the flow chart they used which indicated how and when to share information about a child. If children moved out of the area they informed the child health administration team who ensured records were sent to the appropriate health professional in the child's new location. Health visiting staff made personal contact with health visiting staff and GPs if there were any concerns about a child who moved.
- Health visiting staff attended GP meetings monthly and shared information about children of concern.

Consent

- Staff we spoke with understood and followed legal guidelines of seeking consent from children, young people and their families. Staff were aware of ensuring that the person with parental responsibility had provided appropriate consent for children who were looked after. Parents were asked to provide written consent for any health assessment. We saw children being asked for their consent in an appropriate way for their age and understanding before any actions were taken such as height, weight or vision testing. For example, children who were having health assessments at school entry were not forced but were asked and encouraged if they would engage with the activities. We saw a young person in secondary school being supported to share their concerns about their emotional wellbeing. The member of staff had clearly explained what was being consented to. All school nursing records included details of assessing a young person's ability to consent for themselves following Gillick competencies.
- We saw evidence in the patient records for the No Worries service that consent was obtained and recorded. The provider had a consent policy in place and staff had completed training on consent and also The Mental Capacity Act 2005.
- A service was provided to young people who were under the age of 16. Staff were aware of and knowledgeable about Fraser guidelines and Gillick competence. The Gillick competence identifies children and young people under the age of 16 with the capacity to consent to their own treatment. Fraser guidelines refer to the provision of contraceptive advice and treatment for children and young people without their parents' consent. The No Worries service had its own bespoke confidentiality policy in place. Young people's confidentiality was also protected by the electronic records system which limited access to certain parts of patient's record unless they had permission.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as good because:

- Staff consistently treated children and their families with respect, protected their dignity and were compassionate when responding to concerns.
- Children and families were offered support and staff used caring approaches to help people who found difficulty in expressing their concerns.
- Children and families were offered privacy when it was needed and confidentiality was respected.
- Time was taken to explain options for care and questions were answered honestly and with compassion.
- Parents felt listened to and cared about and were made to feel welcome when they attended any clinic or event held by staff.

Compassionate care

- Staff treated children of all ages and their families with dignity, respect and compassion.
- Baby clinics were held in a variety of locations some of which were in large rooms with waiting areas in the same room. If parents needed private discussion, health visiting staff guided parents to an alternative room to maintain confidentiality. We saw staff treating mothers with kindness and compassion, taking parents' concerns seriously. They discussed any issues and provided information about where to get further guidance if it was needed. One parent said she "felt really welcome" at the clinics.
- Health visiting staff were sensitive to the needs of families from alternative cultural backgrounds and supported them to engage with health services in a way they could accept. As an example, the respect that staff showed to travelling families helped them to engage with health services. A parent told us they attend a clinic every two weeks and meets friends there.
- Staff were sensitive to young people's needs when they attended the school nurse drop in. They treated young people with respect and explained how they would keep information confidential. Their sensitive approach helped young people to discuss their issues.
- We observed No Worries staff interacting with young people and responding with a supportive and constructive approach. People were listened to and given the opportunity to discuss their issues.
- We observed young people were treated with respect and that staff were polite and helpful during conversations. Staff were clear regarding the confidentiality of the patient.

Understanding and involvement of patients and those close to them

- Staff involved children and their families in making decisions about options for their care by providing information in ways they could understand. We saw staff giving reassurance to parents about their child's health and ensuring parents were able to access reliable information before making further decisions about their care. Staff made sure parents felt able to contact them again if they needed further support. Parents with English as a second language were supported by staff to use a language translation service to ensure they understood their options.
- The bladder and bowel service provided information for parents at a clinic one evening. We saw how they used verbal and visual formats in simple language to help parents understand continence issues. Staff gave time to individuals when queries arose and provided honest responses.
- Parents were able to accompany their child to the school entry health assessment. Staff spoke with parents about their child's health and ensured they understood when and how to access further support.
- School nursing staff were non-judgemental in their conversations with young people. They helped young people to understand and make their own decisions about further care.

Good

Are services caring?

- We spoke with two young people who had attended a clinic. They told us they had been listened and had all the questions they answered.

Emotional support

- Staff provided emotional support to children and their families depending upon their need. We saw new mothers had their emotional health assessed after the birth of their child. Emotional support was built into health improvement initiatives such as smoking cessation programmes where new and expectant mothers were encouraged to connect with their expected baby (love your bump). This was an approach health visiting staff used to supported parents to focus on the needs of the baby and form a stronger emotional attachment.
- Parents we spoke with told us the health visiting staff were “very reassuring” and supported them with sleeping/feeding advice. One parent was made to feel “confident about breast feeding” after attending clinics.
- Health visiting staff used an assessment tool to identify if new mothers needed further emotional support. Parents told us they appreciated these questions and felt it was supportive.
- School nursing staff helped children and young people to express their feelings and concerns. They continued to see young people who had to wait for an appointment with Child and Adolescent Mental Health Services to ensure the young person was supported.
- Some school nursing staff used emotionally supportive strategies that helped to promote children’s positive thoughts and reduce the risk of low mood. These strategies involved action from parents and supported the child’s emotional needs when they were at home.
- We saw that in the No Worries clinics several people attended with friends or partners and this was supported and respected by the staff team

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated responsive as good because:

- Senior managers were working with public health and commissioners to identify the priorities for the local population. Staff were encouraged to develop services that worked towards these priorities.
- People were treated equally and those who needed extra help to access services were supported to do so. Translation services were used to help people with language difficulties understand their options. Looked after children were supported with their health needs and young people were given access to health support in schools.
- Referrals were triaged to identify and prioritise people who were in vulnerable circumstances. Staff offered support as a priority over routine referrals.
- Staff ensured that parents and their children had access to relevant and trustworthy sources of information by guiding them to NHS websites and providing relevant leaflets.
- Complaints were reviewed at team meetings and learning points were shared.

However

- School nursing services had a four month waiting list for children and families who needed routine support.
- The No Worries service was commissioned as level one service and meetings were held with the commissioners, but the service specification had limited detail. The size of the service, and the level of service and the frequency and location of clinics did not appear to be based on an evaluation of the needs of the population it served.

Planning and delivering services which meet people's needs

- The service specification for school nursing and health visiting services held little detail, however this contract had been developed by the CCG and not North Somerset Community Partnership. The level of service expected was to meet the needs of children according to the healthy child programme. Senior managers of the children's service were working closely with public health colleagues and commissioners to deliver their service within financial limits. The Joint Strategic Needs Assessment informed managers of the local population's health needs. These supported decisions made about prioritising public health activities. For example, all staff were aware Weston Super Mare included a population of young parents living in an area of high deprivation. A health visiting team was set up to support the needs of young parents in this area. Commissioners had provided funding for 37.5 hours of support to promote stop smoking service for parents who smoked. This service was being reorganised by health visiting staff to encourage greater numbers of parents to achieve success in smoking cessation.
- Health visiting staff tried to provide continuity for families where possible by allocating work to the staff member who knew the family who was requesting support. This helped health professionals to form supportive relationships with parents to benefit their child.
- Managers had identified care that could be delivered by staff with different competencies. For example, health visitors supported new parents within 14 days of a new birth and nursery nurses contacted mothers who were breast feeding between two and six weeks of their child's birth. If further support was needed a Health Visitor would arrange a visit to provide more in depth support. Nursery nurses were supporting a group of breast feeding mothers. This was being held by mothers who had undertaken training to support their peers.
- School nursing staff had identified low attendance at sexual health clinics which were previously school based. A project had been developed to provide holistic health clinics in their place. These were held in the secondary schools and included sexual health advice, emotional health support and signposting advice to other health services. Three schools in North Somerset had these clinics in place and seven other schools had

expressed an interest in offering the service from their premises. School nursing managers used Joint Strategic Needs Assessment information to prioritise which schools needed this service first.

- Children and young people were seen in appropriate areas for their age. School premises were not always the most appropriate for the health assessment activities which were provided but staff were limited by the available space. For example, hearing tests were carried out where there was background noise. Staff were aware of the limitations and did everything they could to ensure extraneous noise was reduced.
- School nursing staff encouraged access to their service by providing information using a range of methods. They attended parent's evenings, provided referral information for schools and other health professionals, displayed posters in schools, provided health reviews for children and drop ins at some secondary schools.
- School nursing staff engaged with schools to run a competition called 'Sharp Shotz' where young people develop a DVD about issues that affect their peers.
- The way school nursing staff were informed of children who attended the emergency department had recently changed to promote more effective use of staff skills. Instead of school nurses reviewing each notification, administration staff reviewed notifications and informed school nurses of children they were already supporting, who had attended the emergency department. School nurses were able to contact children and families to offer further support.
- The bladder and bowel service had a four month waiting list to see children with continence problems. They offered initial support to parents by inviting parents of children who were on the waiting list to attend an information evening. This promoted a first line of action that parents could try to potentially resolve any problems.
- The No Worries service was running twelve clinics a month and an outreach service which operated Monday to Friday between 9am to 5pm. A clinic had been running in a local college but this had not been operating since September 2016 due to the lack of available premises in the college. The clinics were run at three different locations.
- Sexual health services throughout the county and surrounding areas were commissioned by the local authority, local commissioning groups and NHS England. The No Worries service was commissioned as a level one service that was part of the overall provision. The lead explained that she had meetings with the commissioners but the service specification had limited detail. The size of the service, and the level of service and the frequency and location of clinics did not appear to be based on an evaluation of the needs of the population are it served.
- Data was collected from the attendance at the clinics and submitted onto the school nursing department scorecard. It was separated out from the school nursing data on the scorecard. However it was unclear how the data collected was utilised to inform the development of the service.

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Equality and diversity

- Staff used processes which supported people from all backgrounds, religious belief and ethnicity to have equal access to their service. They recognised that some parents and children would have difficulty engaging with their services, which could be because of language difficulties or lifestyle. A telephone language service was used by staff to help parents with language difficulties to understand support that was available and access health care for their children. Staff supported parents of children in Gipsy and travelling families by working in partnership with the local authority.
- A young parent's health visiting team offered more intensive support to young parents in vulnerable circumstances. They contacted parents in a variety of ways to help them to engage. This included telephoning, using email and texting on mobile phones.
- School nursing staff liaised with schools and health visiting staff to identify children who may have difficulties in accessing their service. They used questionnaires for parents to complete and learnt of parents who may have literacy difficulties. Staff could tailor their support to these families and help them to access health services.

Good

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- Staff supported people in vulnerable circumstances to access health by assessing needs, carrying out home visits and providing clinics and drop ins in local areas. Staff used a framework to identify individual needs and vulnerabilities. This was discussed with parents or children and included previous family history, current situation and safeguarding issues. The assessment identified the level of support the family needed. All children were offered universal services which included contact at key points in a child's life. Children identified as having greater need were assessed as needing universal plus or the higher level of support from partnership plus.
- Health visiting and school nursing staff provided enhanced visits for all traveller families on their case load and used alternative methods to engage them in having their child's development monitored. Methods included using a health promotion bus, holding clinics within the traveller sites and using informal walk around visits to engage with families.
- Young parents were supported by a dedicated team of health visiting staff called the young parents team. They offered enhanced visits to parents who were under 19 years of age who were having their first baby or were in vulnerable circumstances. The team were able to offer tailored support and went to great lengths to encourage young parents to attend appointments. They worked on building a relationship of trust with these parents to support the health of their children and families.
- School nursing staff used health questionnaires to identify and support children who had additional caring responsibilities for a member of their family. They could offer drop ins and school visits and ensure they were put in touch with other organisations which could offer peer support for the young people.
- A programme of drop ins was arranged for children in secondary schools. These were held monthly at each secondary school in North Somerset by school nursing staff. This allowed children and young people to access the school nurse without having to inform school staff or their parents. If they were feeling vulnerable or at risk they could express this to the school nurse. We saw school nurses helping young people who were having difficulty in expressing why they had attended the drop in. As an example a tool called 'all about me' was used to help a young person to identify their issues in a pictorial way.
- All schools had school nurses' contact details and could access the team using the telephone.
- Staff attended child protection meetings which were multi agency and could advise on support with health needs of the children in addition to providing visits to families when it was necessary.
- Staff carried out health assessments for children who were looked after within statutory time frames Health information was provided for social workers and foster carers to inform them of actions they needed to take to promote healthy outcomes.
- Staff were consistent in providing parents with relevant and trustworthy information at appropriate times. We saw leaflets used to reinforce conversations about breast feeding. Parents were guided to websites that held correct and current advice such as the NHS website.

Access to the right care at the right time

- Staff used processes of assessment to ensure children and families had timely access to services. Senior health visiting staff reviewed referrals by discussing them as a team. Children and families were prioritised and allocated visits according to their need. This included child development checks, safeguarding and visits for children new to the area. In most areas health visiting teams were providing the agreed development checks for under five year old children. The high level of safeguarding issues in Weston Super Mare was preventing this health visiting team from achieving the same level of development checks for their families needing universal services rather than enhanced. The Weston Super Mare team prioritised the universal visits according to the family's need. For example new birth visits for parents of a second child may be delayed beyond the 14 day target.
- Health visiting teams provided access for parents by operating a 'duty rota'. This meant that a Health Visitor was available in each base from Monday to Friday, within office hours to answer any queries.

Good

Are services responsive to people's needs?

- School nursing staff prioritised needs of children using a system of triage. Information provided on health questionnaires and from referrals were reviewed by a senior member of the school nursing team and children were allocated to a team member for action depending on the urgency. Families were contacted to inform them how long they would need to wait for an appointment or to provide them with information on where to access more urgent support. There was a four month waiting list for children who were assessed as needing a routine appointment although staff would reassess need if further contact was made by the parent or referrer.
- Diabetic specialist nurses enabled newly diagnosed diabetic children to receive support at home instead of having to stay in hospital. They did this by proactively contacting the local children's hospital seven days a week and arranging visits with parents within the week.
- Children who were referred by nursing staff to the Child and Adolescent Mental Health Service (CAMHS) waited for two months for an initial assessment. Nursing staff continued to support these children until their initial assessment and on advice from the CAMHS team following this.
- Staff had reviewed how they offered their services to improve health outcomes. As an example, immunisation sessions were offered to children in schools during school hours but some children found these difficult to attend. New sessions in the evening were being offered for those children who found day time sessions difficult to attend.
- Smoking cessation support that was offered by health visiting staff had been reviewed. This was an opt in service and there had been a high proportion of non attendance at arranged sessions. Health visiting found that people were not engaging for several reasons. This included a feeling by new mothers that they were expected to stop smoking rather than a real desire to. The programme of support for new mothers to stop smoking was in the process of being updated to include; working more closely with midwifery services about identifying mothers who wanted to stop smoking, offering group support, individual support if necessary and motivational rewards of activity vouchers and family swims.
- Doctors from an alternative provider undertook medical examinations for children who were being adopted, looked after and undergoing child protection procedures. Staff told us these doctors were easily accessible and responded promptly to requests for medical examinations.
- The number of people seen at sexual health clinics over recent months was recorded and this showed that they were generally not oversubscribed. However if they were busy staff told they would explain to people how long the wait would be to see a nurse.
- The No Worries service recorded the number of monthly contacts with young people and the reason. Over the three most recent months there were between 80 and 138 contacts recorded for each month. In the most recent month for example it was recorded there were 17 new contacts, 23 re-visits and 98 outreach contacts. Over the month there had been 40 young people who had face to face contact at one of the twelve clinics that had been run.
- The No Worries reception staff explained how they would offer to text people visiting the clinic if there was likely to be a long wait for them to see a nurse. This allowed people to leave and return when the nurse was available to see them.
- Young people were able to approach school nurses for sexual health advice. Cascaded training was provided to them by the lead nurse form the No Worries service. The school nurse could signpost people to other services if required. However we were told there had been limited demand on this service with four enquiries for advice over the eighteen month prior to the inspection.

Learning from complaints and concerns

- Staff were aware of the organisation's policy and supported people to make complaints by informing parents and children of the process. People were informed about how to make a complaint in printed information they received from health visiting and school nursing staff. School nursing staff told us they informed parents verbally at any consultation such as at school entry health assessments. Staff admitted any mistakes made and informed parents how to complain about the error.

Good

Are services responsive to people's needs?

- The organisation had a process to assess how valid a complaint was and whether it needed further investigation. Complainants were sent a letter called a local resolution policy to sign before the complaint was investigated. We saw one of these had not been returned by the complainant and a further letter requesting the signed form was sent with an explanation of its relevance. There was no record that any face to face communication was offered to the complainant and no further investigation took place. Complaints that could not be resolved locally were escalated to managers. Between August 2015 and July 2016 the children's service had received four complaints which had not been upheld as valid. All complaints were analysed for learning points that could be shared across the service at team meetings. An example was a recommendation for a learning event to be held with health visiting staff about documenting discussions with parents.
- The No Worries service used the provider's complaints process. Information about making a complaint or raising a concern was detailed in the written information given to young people attending a clinic. The service had received no complaints within the previous twelve months.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well led as good because:

- The children's service leadership team had a strategy of how they wanted to deliver the service. There had been leadership changes in recent months and managers were in the process of embedding methods for staff to contribute to changes in service delivery.
- Risks associated with the service were escalated and monitoring of how the risks were managed was in place.
- Staff were proud to work for the organisation and liked their roles. They felt they could feed issues up to senior managers and executives and they were listened to at board level.
- Public opinions were sought in a variety of ways which was suitable for the service they offered and where possible changes were made in response to comments.
- Any change in service was monitored and stakeholder's opinions were sought. School nursing staff worked with schools to provide support on a countywide basis rather than for individual schools. This approach had proved popular with schools in the area.
- Staff were keen to improve services and acted on ideas for improvement.
- Staff had good practice recognised in the organisation's quarterly magazine and by receiving awards for specific achievements.
- Managers used opportunities to increase funding by tendering for additional work. This also allowed for the service to be improved with additional staff.

However:

- Some areas were working long hours to provide a safe service and were gaining support from their immediate team but could see no way of the situation improving.
- The No Worries service did not have a formal strategy for the development of the service over the term of the newly acquired contract.
- The identified risk within the No Worries service were not recorded on any risk register. There were clear lines of accountability with staff clear about the reporting and management structures. However there was no indication that risks and service developments around the service were discussed at a senior or board level.

Leadership of this service

- The chief executive officer had been in post for two months before our visit and there had been other recent changes to the executive team. In order to make themselves known to staff they were scheduling visits to locality bases and attending induction programmes for new staff. Not all bases had been visited but a number of staff had met with some of the executive team. The interim chief operating officer provided representation for children's services at the organisation's board meetings. This included monitoring performance of the service and ensuring risks and concerns were raised when it was appropriate.
- The lead of the Children's Service had two assistant service leads for the health visiting service, one for school nursing and a designated nurse for looked after children.
- Health visiting staff worked in five separate localities and were part of an overall health visiting team. Each team had their own team meetings and attended whole health visiting team meetings on a regular basis. A senior health visitor supported the team locally and the whole region health visiting team meetings provided opportunities for wider support and sharing of good practice.
- School nursing staff and their professional lead were located in one building as an office base. The No Worries service and looked after children nurses were located in the same office base.
- Staff said their immediate managers were supportive, approachable and accessible and they felt they were represented at board level. Information was cascaded to

and from the executive team through managers at team meetings and by e mail for those who could not attend the meetings. Staff were clear about how and when they could seek advice from their managers.

- Staff in the No Worries service were positive about their line management. The service was line managed by a manager of one of the health visiting teams and school nursing service and they met regularly with the lead nurse of this service. We were told that managers were approachable and supportive. Whilst staff were positive about their service we were told they were concerned by funding constraints and that there was a lack of understanding about the service from the trust about sexual provision for young people.

Service vision and strategy

- The organisation vision was "healthy communities where people are cared for closer to home" and supported to maintain their independence. The children's service was supported to work in a way that promoted this vision. Staff we spoke with were not all aware of this vision but described similar principles for their own practise. Staff were supported to analyse and redesign their services based on the needs of the population within the area of the county they worked. The children's service leadership team was liaising with commissioners and public health colleagues to collect accurate data of how effective the service delivery was.
- The organisation's staff were shareholders in the company and had helped to develop the values of quality, respect, partnership, effectiveness and integrity. We saw staff upholding the values of the organisation as they treated people with respect and were committed to providing an effective, high quality service.
- Funding had been secured in 2016 for a further five years of provision of the No Worries service. However the commissioning service specification was a very limited document with limited detail around the scope and function of the service. The No Worries service had undergone a rebranding exercise during 2016, though this had amounted to an amendment to the logo of the service and an update to the service web page. The service itself while founded on the appropriate polices and guidance around sexual health and was following national guidance did not have its own bespoke objectives for sexual health provision nor was there a written strategy in place for the development of the service. However at the time of the inspection the service had developed a written standard operating policy that had been submitted to the board of the provider for ratification. This included all the information provided by the service, referral forms and other information such as the information about the Fraser guidelines.

Governance, risk management and quality measurement

- The governance framework supported the delivery of safe and effective care by measuring progress of key indicators. An electronic system was being introduced to measure effectiveness but there had been some discrepancies between electronic and manually held data. The manual data was being used as the accurate measure and electronic data collection was being analysed to ensure it could be collected accurately. This data was presented to executive teams and commissioners every three months. Measures reported included development checks for under five year olds, health assessments for school age children, breast feeding rates, staff sickness and financial information affecting the service. This information was cascaded to staff at team briefings and away days. Staff were clear about their responsibilities, what they were accountable for and knew how well they were performing.
- A Children's Health Service Steering Group met monthly to monitor progress against performance indicators, risks to the service and any new initiatives. This meeting was attended by representatives of public health, commissioning bodies, health professionals and managers of services where children attend.
- The Director of Operations was the lead executive for children's services and was new to the role at the time of our visit but was planning to visit the locality teams for the service. The senior manager attended team meetings when it was possible and met with team leaders regularly to share information from the executive team. A number of meetings supported staff to provide good quality services. Health visiting and school nursing teams met weekly to allocate patients and monitor caseload activity. They met monthly as locality teams to feed information up to senior managers and discuss updates within the organisation. Teams had representatives on governance teams such as infection control and were able to ensure staff were

aware of latest changes to practice based on audit results. However, staff we spoke with were not aware of outcomes or emerging themes from local infection control or record keeping audits.

- A clinical cabinet forum met monthly and was chaired by the director of nursing. Attendance included leads from all clinical areas and discussions included changes in organisational arrangements and professional practice issues. For example, teams of staff were to change to working in localities and the way school nurses responded to notifications of children attending the emergency department was to be altered.
- Risks were identified, placed on the appropriate risk register and discussed at the organisation's board meetings. All senior managers and executives were aware of a recent reduction in funding for the Children's Service. They had identified a high risk that health visiting and school nursing services would be unable to meet corporate strategic aims due to staff numbers being reduced. Mitigating actions had been discussed to maintain safety for children and families. This had included using a specialist community public health nurse to triage referrals to the school nursing service, raising the risks to the clinical commissioning group and working closely with public health commissioners on plans for the future. These actions had been put in place and risks were being reviewed quarterly at performance meetings which were reported senior executives of the organisation.
- We saw that health visiting and school nursing staffing numbers had been added to the corporate risk register, mitigating actions had been taken and were being reviewed. This was because budget cuts to the service had been identified and alternative ways of working were being investigated to support case load management. As an example, the school nursing manager had recently been successful in a bid to provide flu immunisations to children within North Somerset. This had allowed them to expand and restructure school nursing and immunisation services.
- The designated nurse for looked after children monitored quality of nursing input and health outcomes for this group of children. Performance was audited and reported to senior managers which included plans to improve future delivery of the service. Discussions were in process about securing health visiting support for under five year old looked after children although no decisions had been made.
- For the No Worries service there were identified risks that had been discussed with the line management and also the business manager for the service. These were not recorded on a risk register. Potential risks identified during the inspection included the continuity of service due to lack of staffing cover during sickness or annual leave, the vulnerability of some clinics due to lack of service level agreements over the use college facilities. None of these identified risks were formally recorded.
- The lead nurse for the No Worries service attended a management meeting of band 6 & 7 nurses from the school nursing and health visiting service which were held monthly. This enabled them to keep up to date with a range of issues across children's services and any provider wide matters that were being disseminated. There were clear lines of accountability with staff clear about the reporting and management structures. However there was no indication that any risks and service developments around the No Worries service were discussed at a senior or board level.

Culture within this service

- Staff felt respected and valued and able to contribute ideas to improve health outcomes for children and their families. Some staff had felt empowered following attendance at a leadership course and had developed changes to their service which had been sustained for 18 months. This included changes to support to travelling families.
- Staff felt part of their locality team and the wider team of the organisation. Within locality teams they were supportive to each other and monitored caseloads to ensure it was manageable for staff. High caseloads in some areas meant that targets for child contact were not met. The Weston Super Mare team were supportive to each other and their families and had developed a culture of working late in order to maintain safe care for their caseload. Other locality teams recognised that Weston Super Mare had a highly pressurised caseload but were unable to remove this pressure. This was because each base was allocated to GP surgeries and

not to locality areas which could be more flexible. In spite of the pressures all staff said they enjoyed working for the organisation and were proud of what they achieved.

- There was an open and supportive culture within the organisation and staff were keen to learn from colleague's experiences. Incidents were discussed at team meetings and actions for learning were shared.
- Staff wellbeing was invested in by the organisation. All staff were encouraged to access the flu immunisation which was free of charge and could be delivered by the immunisation team. Health visiting staff had taken part in the organisation's 'step challenge' which was an initiative to increase exercise for their staff. Staff were encouraged to maintain their own safety by following the organisation 'lone working' policy. This involved keeping paper diary entries up to date of their intended visits and informing a colleague when they had left an address, if they were visiting a family on their way home at the end of the working day.
- The No Worries staff said they were proud of the service and the feedback they got from the young people. However the lack of insight from the trust in sexual health provision and the number of informal service agreements presented staff with challenges.

Public engagement

- Public engagement was sought by staff in a variety of ways. Each part of the service used evaluation feedback forms at the time of delivering an intervention to children and families. This included at parent's information evenings, after consultation with nursing staff, child health reviews and school health information days for teaching staff. Children had their own evaluation forms which used a number scale and smiley faces to indicate satisfaction scores. It included simple questions such as "did nurses clearly explain what you had to do" Evaluation forms included the question about recommending the service to friends and family. These forms could be returned to nursing staff at schools, health centres, in person and by post. Results were analysed and changes made where possible. For example, school entry health assessment appointment times had been increased to 20 minutes each in response to parents feeling rushed at 15 minute appointments.
- Friends and family responses were measured and reported for the service. Between January and March 2016, responses from each of the 38 forms returned were positive.
- The provider completed the national friend and family tests. Patients could provide feedback either at every contact or on discharge from a service via a mobile device, return of prepaid cards or using the link on the provider web site. During the three months prior to the inspection the responses showed that 98% of patients would recommend the services and 99% felt that overall a good service was provided. 99% of patients said that they were treated with dignity and respect.
- Within the childrens services there were 38 recorded replies and all said they would recommend the service. The responses for the No Worries service were co-ordinated within the school nursing data and there had been no direct response for this service from the Friends and Family Test.

Staff engagement

- Views of staff were sought at team meetings and away days and staff were encouraged to contribute to the organisation wide annual staff survey. Results of the staff survey were presented for the overall organisation and trends were compared to previous years. From staff who had responded to the survey questions, 11 of the questions had shown improvement. This included staff feeling the organisation delivered value for money services and that staff felt they were treated fairly in the event of an error, near miss or incident. Results were worse for 33 of the questions and included staff being less aware of the organisation strategic aims and being less able to make suggestions about the way they work. Methods of building engagement across the organisation were identified following this survey.
- Health visiting staff had forums every three months where current professional issues were discussed. An extra away day was held in September 2016 which focussed on what health visiting staff felt could be improved upon to meet the financial pressures of the organisation and maintain quality and safety of the service. This was in response to a reduction in public health funding for the service
- Some staff felt the young parent's team would be redesigned and absorbed into the general health

visiting team. They thought the high level of need their parents experienced would add to health visitor's caseloads and become unmanageable. Senior managers had attended a team meeting to reassure health visiting staff that there would be no cuts to the health visiting service but at the time of our visit staff we spoke with were still concerned.

- School nursing staff could feed back at team meetings and had an away day planned to contribute ideas for practice improvement. Actions had been initiated based on school nursing team feedback. This had included the change in process for triaging notifications about children's attendance at urgent care centres.
- Staff were given professional areas of responsibility which helped them to feel empowered and involved. They were able to feed information between their teams and specialist teams such as the workforce learning and development forum, infection control team, safeguarding team.
- Children's services staff had articles published in the organisation's 'pulse' magazine which updated staff on services and what they delivered.
- Health visiting and school nursing staff told us they felt able to provide feedback to managers.

Innovation, improvement and sustainability

- Staff were engaged in projects to improve services for children and their families. The provision of these initiatives was based on research findings and nationally available evidence. For example, health visiting staff used available research on what works with group support to encourage expectant mothers to be successful in stopping smoking. Some projects had been running for more than 18 months and attendance had been reviewed. This had altered the way the service was delivered and had given a benchmark for success. For example, traveller families did not readily attend baby clinics. Staff worked with partner agencies to provide a more informal form of support which helped mothers to engage with health advice for their children.
- School health clinics which were holistic rather than dedicated sexual health clinics were in demand by schools. More schools had expressed an interest in having these clinics on their premises but not enough staff were available to meet the demand.
- School nursing staff engaged with schools to run a competition called 'Sharp Shotz' where young people develop a DVD about issues that affect their peers.
- The organisation recognised staff achievements and innovation with an award event. The bladder and bowel service showed us an award they received for parent information evenings. This was an initiative that provided information for parents whose children were on the waiting list for the service and could prevent an unnecessary appointment. Health visiting staff in Weston Super Mare received an award to recognise their work in supporting vulnerable families.
- Support for children with medical needs in schools had been reviewed and was being delivered in a way that was more sustainable. Support to each of the schools on how to manage conditions such as asthma, epilepsy and severe allergies was being offered at an annual training day instead of at individual school locations. This had proved to be popular with school staff and well attended.
- Managers took opportunities to increase funding by tendering for programmes of work. One example was the immunisation contract for schools in North Somerset. This funding had allowed an increase in staffing numbers and enabled a restructuring of the service for greater efficiency.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (1) Sufficient numbers of suitable qualified, competent, skilled and experienced persons must be deployed. 18 (2) (a) Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform: Health visiting teams had higher numbers of children on their caseloads than recommended by the Community Practitioners and Health Visitors Association. Some localities had very high numbers of children who needed additional support. This meant there were insufficient staff and led to health visiting staff working beyond their contracted hours to provide a safe service and there was little capacity for unexpected and sudden staff absence. The impact was that not all children received the universal service as outlined in the health child programme to ensure healthy outcomes.