

Lancashire Care NHS Foundation Trust

RW5HQ

Community health services for children, young people and families

Quality Report

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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)
RW5HQ	Ashurst Health Centre	Health Visiting	WN8 6QS
RW5HQ	Avenham Health Centre	Health Visiting	PR1 3RG
RW5HQ	Leyland Clinic	School Nursing	PR25 2TN
RW5HQ	Ribbleton Health Centre	School Nursing/Health Visiting	PR2 6HT
RW5HQ	Penwortham Health Centre	School Nursing/Health Visiting/ Immunisation Team	PR1 0SR
RW5Y8	Ashton Health Centre	Family Nurse Partnership/Infant Feeding Team	PR2 1HR
RW5HQ	Acorn Centre	Childrens Integrated Therapy and Nursing Service	BB5 1RT
RW5HQ	Broadoaks Child Development Centre	Paediatric Therapies	PR25 3ED







This report describes our judgement of the quality of care provided within this core service by Lancashire Care NHS Foundation Trust. 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 Lancashire Care NHS Foundation Trust and these are brought together to inform our overall judgement of Lancashire Care NHS Foundation Trust

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, we have judged that community health services for children, young people & families is “Good”. This is because:

- Staff knew how to report incidents and reported receiving feedback in a number of ways. Staff could describe incidents that had been reported and identified actions taken in response.
 - The trust had implemented “Risk sensible” approach safeguarding training for all practitioners in the children and families network. This assisted with the identification of risk and enabled effective communication with social care colleagues using a common language.
 - Paper and electronic records we reviewed were completed to a good standard and included relevant patient information including name, address, date of birth as well as care plans, referrals and safeguarding information as appropriate.
 - All clinical areas we visited were visibly clean. We observed handwashing and infection control practices in home visits and at a baby clinic, appropriate cleaning of equipment between patients and use of personal protective equipment.
 - Caseloads in universal services for children and young people were weighted to ensure a standardised approach to decision making across the trust and the weighting of each child was clearly identified on the electronic care record (ECR).
 - The service used National Institute for Health and Care Excellence guidelines to determine care and treatment. Health visiting and school nursing teams worked to deliver the Healthy Child Programme and two of the five contacts were delivered using the Ages and Stages evidenced based screening tool.
 - Health visitors used tablet computers to access records and document contacts while in clinic settings or during family visits. The use of internet software allowed staff from across bases to connect in to daily huddles without the need to travel and
- ‘Chat Health’ was being introduced across the school health service which allowed students and parents to contact the school health service by telephone and text in a confidential and accessible manner.
 - We observed several examples of multi-disciplinary working during our inspection, in both health and education settings, with clinicians collaborating to support the planning and delivery of care to children, young people and their families.
 - Contacts we observed showed information provided to children and families was clear and tailored to the individual child. Families were offered choice regarding their child’s care and given the opportunity to ask questions. Families engaged with the Children’s Integrated Therapy and Nursing Service were involved in writing their child’s care plan.
 - The Children’s Integrated Therapy and Nursing Service staff arranged joint visits to families to reduce the need for attendance at multiple appointments and health visitors in the West Lancashire area had returned to individual allocation of community clinics to promote continuity for families in response to service user feedback.
 - The Family Nurse Partnership was offered in the Preston and Burnley area to first time mothers aged 19 years and under to improve health, social and educational outcomes. Identified liaison health visitors were in post to provide support and advice to families placed in a refuge and safeguarding specialist nurses worked in partnership with other agencies to provide health assessment, advocacy and support for children and young people involved with the youth offending team or identified as being at risk of child sexual exploitation.
 - The Clinical Director for the children and families network provided a monthly quality and performance report to the Quality and Safety sub-committee and performance was monitored against a variety of targets and data. Staff we spoke with

Summary of findings

were aware of the key performance indicators relevant to their role and individual performance was reviewed in monthly one to one meetings with their line manager.

- We observed strong leadership from team leaders and managers and staff spoke positively about the team leaders, describing them as visible, accessible and supportive. Monthly team meetings took place to ensure staff received information and feedback regarding incidents and complaints and were kept informed of developments within the trust.
- The safeguarding team were not routinely being copied in to referrals made to children's social care. This meant that managers did not have an accurate picture of safeguarding activity across the trust.
- Safeguarding supervision was practitioner-led and delivered in a group setting where each practitioner would bring one case to discuss. While safeguarding specialist nurses were available to provide telephone advice and team leaders were available for ad hoc support, this meant that not all safeguarding cases were subject to objective, critical reflection.
- At the time of our inspection the antenatal contact was not being delivered consistently to all pregnant women in the trust. Staff and managers told us that there were delays receiving information about patients accessing antenatal care from local acute providers and this was recorded on the trust risk register.
- Annual appraisal rates for non-medical staff in community health services for Children, Young People and Families was 73%. Compliance rates in individual teams ranged from 29% (6 out of 15 staff) in the Blackburn with Darwen CITNS team to 100% in the 0-19 South Ribble East team (19 staff).
- From January to August 2016 referral to treatment times for occupational therapy consistently missed the 92% standard averaging 73% in this time period.
- From January to August 2016 referral to treatment times for speech and language therapy consistently missed the 92% standard averaging 89% in this time period.

Summary of findings

Background to the service

Lancashire Care NHS Foundation Trust delivers a range of community based services to children and young people across Lancashire. Lancashire covers a wide geographical area from Ormskirk and Skelmersdale in West Lancashire, through Chorley, Leyland and Preston in the centre, over to Blackburn with Darwen and Accrington in the east. Services include health visiting, school nursing (including special school nursing), nursing for children with complex needs, speech and language therapy, occupational therapy and physiotherapy. Services are provided in a variety of community settings including home visits, and within schools and health centres.

The trust also delivers the Family Nurse Partnership (FNP). This enhanced home visiting programme for first time mothers under the age of 19 years has been delivered in Lancashire since April 2015. The FNP provides a service in central Preston and Burnley, the service in Blackburn with Darwen was decommissioned on 31 August 2016, shortly before our inspection. Community health services for children, young people and families forms part of the children and families network within the trust.

Our inspection team

Our inspection team was led by:

Chair: Neil Carr OBE, Chief Executive South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Inspection Managers: Sharon Marston and Nicola Kemp, Care Quality Commission

The team for community services for children, young people and families included two CQC inspectors, a health visitor, a school nurse and a head of safeguarding.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

We carried out a comprehensive inspection in April 2015. We found the service was in breach of Regulation 12: Safe care and treatment and Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service had met the requirements relating to the previous breaches we issued during this inspection.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about this service and asked other organisations to share what they knew.

We carried out an announced inspection between 12 to 15 September 2016 and an unannounced visit on 27 September 2016.

Prior to the visit we held focus groups with a range of staff who worked within the service, such as health visitors, school nurses and therapists. We also interviewed the Network Director and Clinical Director for the children and families network.

During the visit we spoke with 91 members of staff at all levels including managers, senior managers, named safeguarding nurses, health visitors, school nurses,

Summary of findings

administration staff and members of the children's integrated therapy and nursing service. We talked with ten service users and we reviewed 34 care records. We observed how people were being cared for in their own

homes, in clinics and in schools. Patients and families also shared information about their experiences of community services via comment cards that we left in various community locations across Lancashire.

What people who use the provider say

Service users spoke highly of the service and as part of the inspection we asked parents, children and young people, to share their thoughts about the community service through completion of a comment card. The responses were positive and included the following comments:

In health visiting service feedback included: "The service is brilliant and my health visitor is amazing, she goes above and beyond to make sure us Mums are ok too". "I received very caring advice from my health visitor whilst I was suffering with depression. Staff were very thoughtful and gave me advice and treated me with dignity and respect throughout".

Good practice

- Training in newborn behavioural observations (NBOS) was being rolled out to health visiting teams. NBOS is a tool designed to promote positive bonding between parents and children.
- Speech and language therapists had devised a training and resource pack which had been sold to schools.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the trust **MUST** take to improve

- The trust must ensure that all safeguarding cases are subject to objective, critical reflection.
- The trust must ensure that safeguarding activity is monitored across the service.

Action the trust **SHOULD** take to improve

- The trust should ensure that equipment provided to children and young people in the community is provided in a timely manner.
- The trust should ensure an antenatal contact is offered consistently to all pregnant women in the trust.
- Staff should have their learning needs identified through the trusts appraisal process.
- The trust should ensure timely access to paediatric occupational therapy and speech and language therapy.

Lancashire Care NHS Foundation Trust

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 community health services for children, young people and families as 'Requires Improvement' in the safe domain because:

- The safeguarding team were not routinely being copied into referrals made to children's social care. This meant the safeguarding team did not have an accurate picture of safeguarding activity across the trust.
- Safeguarding supervision was practitioner-led and delivered in a group setting where each practitioner would bring one case to discuss. While safeguarding specialist nurses were available to provide telephone advice and team leaders were available for ad hoc support, this meant that not all safeguarding cases were subject to objective, critical reflection.

However:

- The trust had implemented "Risk sensible" approach safeguarding training for all practitioners in the children and families network. This assisted with the identification of risk and enabled effective communication with social care colleagues using a common language.
- Since our last inspection a new standard operating procedure had been introduced to provide best practice in the delivery of immunisations and the trust had purchased mobile thermometers to ensure accurate temperature monitoring of vaccines during immunisation sessions in schools. Vaccines were stored in fridges and records we reviewed indicated that temperatures were recorded daily to ensure that vaccines remained within the required temperature range.

Safety performance

Are services safe?

- In the period 2 April 2015 to 27 March 2016, of the 118 serious incidents reported to the Strategic Executive Information System by the trust, four serious incidents related to community health services for children, young people and families.
- These included three classed as unexpected or avoidable death or severe harm of one or more patients, staff or members of the public and one classed as a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incident in population programmes like screening and immunisation where harm potentially may extend to a large population. Three of the incidents involved patients under the care of the children's integrated therapy and nursing service (CITNS) which included the continuing packages of care team (CPOC).
- A review of two of the incident reports showed investigations identified any issues of concern, action taken following the investigation, where appropriate, and gave detail regarding duty of candour.
- There were a total of 50 child deaths in the six month period prior to our inspection which went to the Child Death Overview Panel (CDOP). Of these, 14 were for unexpected child deaths and 36 were for expected or neonatal deaths. The trust participated and contributed to a review of these deaths and a specialist nurse for Sudden Unexpected Death in Childhood (SUDC) acted as a link to the regional panel. Learning identified for the trust related to the 'Did Not Attend' (DNA) policy for the Child and Adolescent Mental Health Service (CAMHS), however, co-sleeping was a factor in a number of the deaths reviewed and further funding had been identified for the Safer Sleep Campaign.

Incident reporting, learning and improvement

- Incidents were reported through an electronic reporting system. At the last inspection, staff had a varied understanding around the categories of incidents to report. Staff we spoke with on this inspection could describe the process and type of incidents that required completion of an incident form.
- Between 1 September 2015 and 31 August 2016, 326 incidents were recorded by children and family services, the children's integrated therapy and nursing service (CITNS), the Family Nurse Partnership (FNP), the

immunisation and vaccination team, and the complex packages of care team. Of these, 256 were categorised as insignificant or low harm. Twenty seven incidents related to records, 18 to vaccination and immunisation and nine to safeguarding.

- Staff could describe incidents that had been reported and identified actions taken in response.
- Staff we spoke with were able to discuss changes to practice as a result of serious case review such as completing two year developmental reviews in the home rather than a clinic environment. A serious case review takes place after a child dies or is seriously injured and abuse or neglect are thought to be involved.
- Staff we spoke with reported receiving feedback in a number of ways including individually from the team leader, in daily communication "huddles" and electronically in the weekly trust wide email.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with did not always recognise the term but described principles of honesty and transparency if something went wrong.

Safeguarding

- Safeguarding specialist nurses provided monthly one to one safeguarding supervision for staff for a year following qualification. A telephone advice line was also available should any practitioner require immediate advice.
- Monthly one to one management supervision provided an opportunity for ad hoc child protection supervision with team leaders.
- Practitioners participated in group supervision of child protection cases, three monthly as a minimum, facilitated by team leaders, safeguarding champions and community practice teachers. This was practitioner led and staff would choose a case they were working with to take to the group. Due to the model of supervision this meant that not all safeguarding cases were subject to objective, critical reflection.

Are services safe?

- We reviewed 28 records of children with current social care involvement. Of those reviewed 16 had not received safeguarding supervision.
- Managers told us that they were assured that all team leaders had received clinical supervision training and had attended half day safeguarding supervision training to deliver this model. Data from the trust showed that, between December 2015 and Sept 2016, of the 41 places offered for workshops, 12 places were filled by Universal Service staff.
- A child protection case tracking and quality audit in September 2015 identified that the safeguarding team were not routinely being copied in to referrals made to children's social care. The current safeguarding and protecting children policy amended in August 2015 confirmed this requirement, however both staff and managers we spoke with told us this did not happen. Of the 28 records of children reviewed with current social care involvement, four had the initial referral completed by the current practitioner and in three of the four cases it could not be evidenced that the safeguarding team had been copied into the referral. This meant that managers did not have an accurate picture of safeguarding activity across the trust.
- An annual safeguarding report was presented to the board in July 2016 for the period 2015/16 which contained information regarding key achievements, challenges and performance monitoring. It also identified key strategic priorities for 2016/17.
- A Care Quality Commission review of health services for Children Looked After and safeguarding in Lancashire was published in August 2016. Recommendations for Lancashire Care NHS Foundation Trust included strengthening its approach to identifying risks to children of parents with mental ill-health to ensure effective initial and ongoing review of risks and sharing expertise to inform partnership working. This also identified the trust should ensure records of actions discussed in supervision were routinely recorded on the case records of young people to provide assurance about the effectiveness and impact of work to address risks and support improved outcomes.
- Managers and staff told us that a Local Authority Ofsted inspection published in November 2015 had a significant impact on the trust due to a number of complex cases being reassessed and managed under child protection plans rather than at a Child in Need level.
- In response to an increased number of invitations to initial child protection conferences, managers had liaised with local authority colleagues regarding attendances at child protection conferences and provision of health information at short notice. It had been agreed that notice of five days was required for production of a full report for a child protection conference.
- Policies and procedures were in place to safeguard children including a pathway for dealing with Female Genital Mutilation.
- Training data for the children and families network showed there was a 98% compliance for safeguarding children level one and 92% compliance for safeguarding children level three which were better than the trust target of 85%. No practitioners were identified as requiring level two training. Safeguarding vulnerable adults training level one had a compliance rate of 92% and safeguarding vulnerable adults level two training compliance rate was 35%.
- The trust had implemented "Risk sensible" approach training for all practitioners in the children and families network. Staff told us this had been a positive practice development as it assisted with the identification of risk and enabled effective communication with social care colleagues using a common language.
- The safeguarding group held meetings quarterly and discussed issues such as training, safeguarding risks and safeguarding activity across the trust.
- Electronic care records flagged any cases subject to safeguarding involvement and more detailed information could be obtained by accessing a further screen.

Medicines

- An immunisation and vaccination team planned and delivered all immunisation programmes for school aged children both in educational settings and in home visits.
- To maintain the cold chain, vaccines were stored in fridges and records we reviewed indicated that temperatures were recorded daily to ensure that

Are services safe?

vaccines remained within the required temperature range of between two and eight degrees Celsius. Maximum and minimum temperatures were also recorded in accordance with national guidance.

- At our last inspection it was identified that the temperature of a cool box used to transport and store vaccines to a school had risen to 10 degrees centigrade during the vaccination session which could have potentially affected the cold chain storage of the vaccinations making them unfit for use. Since our last inspection the trust had purchased mobile thermometers to ensure accurate temperature monitoring of vaccines.
- A new standard operating procedure (SOP) had been introduced to provide best practice in the delivery of immunisations. This included monitoring vaccine temperatures during transportation as well as actions required should storage conditions deviate from the recommended range.
- There were no school vaccination sessions scheduled during our inspection, however staff were familiar with the SOP and could describe the process for immunisation delivery in school.
- Quarterly cold chain audits were completed by the medicines management team.

Environment and equipment

- The clinical areas we visited ranged from modern purpose built primary care centres to older, longstanding clinic buildings. All were visibly clean and had ample seating.
- We saw evidence that equipment, such as baby scales, were appropriately checked and calibrated to ensure accuracy.
- We observed physiotherapy equipment that had been serviced and safety tested.
- Staff we spoke with in the CITNS team advised that an external company had been commissioned to provide equipment for children and young people in the community. Issues were reported regarding delays accessing equipment which, on occasion had impacted on care delivery. This had been identified as an open risk for community child health services and was being monitored by the commissioning lead.

- At our last inspection it was observed that the environment in schools where immunisations were carried out did not always promote a calm and safe environment. Staff told us that the organisation of immunisation sessions had been altered to allow more space between “immunisation stations” and a separate room was identified for children who would like a more private environment or who need to undress.

Quality of records

- There was a combination of electronic and paper records used in the trust, depending on speciality.
- Health visitors and school nurses used an electronic care record (ECR). This included information regarding a patient’s name and address, next of kin and GP as well as contact details for other professionals involved with the family. All contacts and significant events were recorded on a range of easily navigated screens and any paper correspondence received regarding the child was scanned on to the record. The records we reviewed were up to date and complete.
- The ECR alerted staff to the weighting of a case. This identified the current level of involvement with the child and family and ranged from universal which signalled routine intervention to universal partnership plus which indicated more frequent, targeted intervention.
- Home contacts were recorded on a tablet computer following the visit and synchronised to the main patient record on return to the base. Any patient information on the tablet was automatically erased at midnight on the same day.
- All previous paper records were in the process of being scanned onto the system, however staff told us they were accessible if required in the meantime.
- Therapies staff used paper records within the child development centre and, of the six sets of records reviewed, all were legible, up to date and contained relevant patient information including name, address, date of birth as well as care plans, referrals and safeguarding information as appropriate.
- The ECR could be accessed from other bases enabling staff to input data from any trust site. Information relating to contacts with other disciplines could also be reviewed to inform practitioners regarding attendance at clinic appointments, for example speech therapy.

Are services safe?

- A record keeping audit was completed in February 2016 which indicated that the Family Nurse Partnership (FNP) achieved 87% overall compliance with the standards of the trust's record keeping policy. The audit of the ECR used by universal services for children and young people found that, of 24 standards reviewed, the service was fully compliant with 10 and partially compliant with five. Action plans had been drawn up to address areas of non-compliance and a further audit was scheduled to review the content of entries made.
- Overall compliance with core training for the children and families network was 90% against a trust target of 85%.
- Compliance for individual subjects ranged from 75% for manual handling to 98% for two yearly infection control.
- Essential training for children, young people and families included Mental Capacity Act level one and level two, Mental Health Act level 2, PREVENT and violence reduction training. Compliance rates ranged from 79% for Mental Health Act level 2 training to 47% for Mental Capacity Act level 2 training.

Cleanliness, infection control and hygiene

- The clinic areas we visited during the inspection were visibly clean.
- Infection control training was part of the trust's mandatory training programme and was delivered yearly for clinical staff and two yearly for administration staff. Compliance rates for the children and family's network was 92% for clinical staff and 98% for administration staff.
- As part of the inspection we attended home visits and observed a baby clinic in a health centre. We observed appropriate handwashing and infection control practices. This included the use of personal protective equipment, where appropriate, such as aprons.
- We observed appropriate infection control measures in a baby clinic which included the cleaning of hands, mats and scales in between patients.
- Infection control champions were identified in each team to inform staff regarding information updates, changes to procedure or any current issues.

Mandatory training

- Staff completed core and essential mandatory training. Core training included subjects such as fire safety, equality and diversity, information governance and infection control. Essential training was specific to individual roles.
- Training was delivered in a combination of online programmes as well as face to face sessions. Due to the wide geographical spread of clinic locations within the trust the training department had begun to deliver bespoke sessions in team bases. This had increased compliance and reduced the necessity for practitioners to travel long distances to access training.

Assessing and responding to patient risk

- Care plans were in place for children with complex needs with a named contact who had parental responsibility.
- The complex packages of care team (CPOC) who directly delivered care in the home used a care plan called "All about me". This provided an assessment of the child based on activities of daily living and included specific information to support parents to work with their child. This document remained with the child at all times.
- Managers told us there was no current palliative care service for children provided by the trust, however staff worked closely with local children's hospices and acute trusts and an end of life pathway was in development at the time of our inspection.
- At our last inspection it was noted that not every clinic location used, but not owned by the trust, had a risk assessment. At this inspection it was noted that a health, safety and environment assessment for third party settings was now in place in the trust. This was completed in three stages, a general environmental assessment, an assessment of suitability for the specific clinical activity and rooms to be used and finally a dynamic risk assessment completed each time the room was used.
- Staff confirmed that, prior to each immunisation session in school the dynamic risk assessment was completed and stored electronically.
- The assessments we reviewed included any required actions identified that were specific to the individual environment for example a member of school staff to be present with students due to challenging behaviours.

Are services safe?

Staffing levels and caseload

- The health visiting and school nursing teams used the Benson Model to inform workforce planning. This looked at distribution of staff within teams taking into account caseload numbers, the requirements of the local population and the geographical area.
- Caseloads in universal services for children and young people were organised geographically but also weighted using a child and family weighting tool. This ensured that a standardised approach to decision making was used across the trust and the weighting of each child was clearly identified on the ECR.
- The weighting tool used vulnerability factors for example relating to a child's development needs or family and environmental factors to help staff determine the required level of intervention.
- Health visiting, school health and therapies staff received monthly one to one caseload management supervision with the team leader who would review the weighting of caseloads to ensure equity of workload. Staff told us this was effective in ensuring that workload was evenly distributed in relation to complexity of families and hours worked.
- Vacancy levels of qualified nurses and nursing assistants in the health visiting, school health and immunisation teams as at April 2016 were nine and four percent respectively.
- The average of total vacancies across services for children, young people and families in the same period was 11.8% against a trust average of 12.5%.
- Average sickness levels across services for children, young people and families as at April 2016 were 5% against a trust average of 4.8%.
- Managers told us pressures had been experienced in school health and this was recorded on the risk register for community child health services. Actions had been put in place to address this risk including forming duty 'hubs' and early recruitment to school health staff nurse posts in advance of staff leaving to undertake student health visiting and school health posts. At the time of our inspection data from the trust showed 1.6 whole time equivalent vacancies for the school nursing service.

- Risk assessments were completed as part of an initial assessment for a child and family. We observed information on an ECR which stated that no home visits were to be conducted. A risk assessment was also attached to the file.
- A lone working policy was in operation across the trust and we observed white boards in staff bases indicating the location of some individual practitioners.
- Staff told us that, on exiting visits at the end of the day, practitioners would telephone the duty staff member to confirm they were safe before going home and electronic staff diaries could be accessed by other members of the team if required.
- Daily staff huddles took place every morning in school health and health visiting teams and included any relevant information required by staff that day including cover for clinics, any staff members absent for training and details of the practitioner acting in a duty role for the day. The duty role involved dealing with phone calls, information requests from social care and allocation of work as well as triaging any notifications of attendance at emergency departments.
- Guidance was provided for schools following immunisation sessions in case a student reported that they felt unwell once they had returned to class.
- Managers told us that winter management plans were in place to mitigate any impact of adverse weather in the provision of services to children with complex needs such a redeployment of staff. The ECR could also be accessed at all bases throughout the trust allowing staff to work from their nearest base should they be unable to reach their usual place of work.

Major incident awareness and training

- The trust had a major incident policy which listed key risks that could affect the provision of care and treatment. Staff were aware of the policy and could locate it on the intranet.
- Managers told us they were aware of the business continuity plan which was updated quarterly.
- The trust provided health and safety training and fire safety training as part of core mandatory training. Data

Managing anticipated risks

Are services safe?

supplied by the trust indicated that compliance rates in the children and family's network was 94% and 92% respectively, which was better than the trust target of 85%.

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 community health services for children, young people and families as 'Good' in the effective domain because:

- The service used National Institute for Health and Care Excellence guidelines to determine care and treatment. Health visiting and school nursing teams worked to deliver the Healthy Child Programme and two of the five health visiting contacts were delivered using the Ages and Stages evidenced based screening tool.
 - We observed several examples of multi-disciplinary working during our inspection, in both health and education settings, with clinicians collaborating to support the planning and delivery of care to children, young people and their families.
 - A good practice statement had been written entitled 'Using Gillick Competence to Gain Consent for Immunisations in the School Setting'. This described how the use of the Gillick competence assessment was found to be a highly effective process that empowered students to take responsibility in relation to their health needs.
 - At the time of our inspection the antenatal contact was not being delivered consistently to all pregnant women in the trust. Staff and managers told us there were delays receiving information about patients accessing antenatal care from local acute providers and this was recorded on the trust risk register.
 - Annual appraisal rates for non-medical staff in community health services for children, young people and families was 73%. Compliance rates in individual teams ranged from 29% (six out of 15 staff) in the Blackburn with Darwen CITNS team to 100% in the 0-19 South Ribble East team (19 staff).
- provided, for example guidance on pressure ulcers used by the complex packages of care (CPOC) team or breastfeeding guidance used by the health visiting service.
- Health visiting and school nursing teams worked to deliver the Healthy Child Programme. This is a universal early intervention and prevention public health programme that includes five core contacts offered between the ages of 0-5 years. At the time of our inspection the antenatal contact was not being delivered consistently to all pregnant women in the trust. Staff and managers told us there were delays receiving information about patients accessing antenatal care from local acute providers, this was recorded on the trust risk register and action was being taken to improve this.
 - Two of the five contacts offered at nine to 12 months and two to 2.5 years were health and development reviews and health visiting teams were using the Ages and Stages questionnaires to complete the assessments. This is an evidenced based screening tool designed to recognise achievement of developmental milestones and to detect delay.
 - The Family Nurse Partnership (FNP) was delivered in the Preston and Burnley areas of the trust. FNP is a home visiting programme offered to first time mothers aged 19 years and under to improve health, social and educational outcomes.
 - Training in newborn behavioural observations (NBOS) was being rolled out to health visiting teams at the time of our inspection. NBOS is a tool designed to promote positive bonding between parents and children and staff reported parents had been very receptive to information provided regarding brain development in their newborn.
 - Level three Baby Friendly accreditation had been achieved across Lancashire Care children and family health service.
 - Up to date guidance was disseminated to staff in team meetings and on team notice boards.

Evidence based care and treatment

- The service used National Institute for Health and Care Excellence guidelines to determine care and treatment

Are services effective?

- Local audits were completed to assess if guidance was followed and a local audit completed in June 2016 in relation to immunisation and vaccination processes in children demonstrated overall compliance of 97%.
- Care pathways were in place for perinatal mental health and Autistic Spectrum Disorder.

Pain relief

- Advice regarding pain relief was given following immunisation. We observed information and advice given by telephone to a parent in case of pain or temperature following their baby's immunisations.

Nutrition and hydration

- An infant feeding team was employed across the trust and was commissioned to deliver the Baby Friendly Initiative to local authority community services.
- Health visitors provided information and advice regarding infant feeding including breastfeeding at routine contacts and in clinic settings.
- Dietetic support was provided by local acute trusts and included provision of advice to professionals and joint visits to families. Staff described examples of multi-disciplinary working with speech and language therapists for children with feeding and swallowing difficulties.
- The CPOC team supported parents with feeding regimes as part of a child's package of care.

Technology and telemedicine

- Health visitors and school nurses used tablet computers to access records and document contacts while in clinic and school settings or during family visits, however staff told us that connectivity could be variable in some areas. This information was then synchronised to the electronic care record (ECR) on return to the base.
- The use of internet software allowed staff from across bases to connect in to daily huddles without the need to travel.
- 'Chat Health' was being introduced across the school health service during our inspection. This allowed students and parents to contact the school health service by telephone and text in a confidential and accessible manner using technology many children are familiar with.

- Referrals to CITNS was by completion of a single point of access form which was sent to the referral and appointments centre. This allowed professionals to triage referrals electronically and staff told us this had made the process much more efficient.

Patient outcomes

- The trust was working towards offering an antenatal contact to every pregnant woman from 28 weeks. Data provided by the trust indicated that between April and June 2016 69.7% of all known pregnant women across the trust received a face to face visit by 28 weeks or above by a health visitor, against a target of 95%. Staff and managers had told us they had experienced some delays obtaining information about patients receiving antenatal care from local acute providers; however action was being taken to address this.
- The healthy child programme states that a birth visit should take place within 14 days of delivery in order to discuss topics such as infant feeding, reducing the risk of sudden infant death syndrome, parenting, child development and assessment of maternal mental health. Between April and June 2016 94% of families across the trust received a face to face new birth visit within 14 days of birth by a health visitor against a target of 95%
- Two further contacts stipulated by the Healthy Child Programme are developmental reviews. One should be conducted by 12 months of age and the second between two and 2.5 years of age. Between April and June 2016 96% of children across the trust received a review from a health visitor by 12 months of age against a target of 95% and 97% of children across the trust received a two to 2.5 year review against a target of 95%.
- School health teams monitored performance in relation to the National Child Measurement Programme (NCMP) which measures the height and weight of children in reception class (four to five years of age) and year six (10-11 years of age). Data from the trust indicated that, by July 2016, the percentage of children weighed and measured in both cohorts across the trust achieved the target range of between 90% and 95%.

Are services effective?

- Preschool immunisations were delivered by GP practices and the trust advised they did not hold any data for this age group. This meant that the trust did not have any intelligence regarding immunisation uptake for preschool children in Lancashire.
- All girls aged 12 to 13 years of age are offered HPV (human papillomavirus) vaccination. By July 2016 rates across the trust ranged between 85% and 89% for year eight pupils and 85.5% to 89% for year nine pupils against a target of 90%.
- All young people aged 14 years are offered a Diphtheria, Tetanus and Polio booster vaccination. By July 2016, rates across the trust for students in year 10 ranged from 90.8% to 92% against a target of 90%.
- All young people aged 14 years are offered the Meningitis ACWY vaccination. By July 2016, rates across the trust ranged from 90.7% to 91.8% for students in year 10 and 90.6% to 92.4% in year 11 against a target of 90%.
- Breastfeeding prevalence (any breastmilk) at four to six weeks for January to March 2016 was 40% in the East of the trust and 40.9% in Central and April to June 2016 it was 39.8% in the East and 42.5% in Central.
- FNP data between September 2015 and August 2016 indicated that 64.1% of clients were enrolled with the programme within 16 weeks gestation against a goal of 60%.

Competent staff

- A staff development and assurance framework was in place which defined the competencies required by staff delivering universal children and family health services according to their job role. We observed individual competency documents and staff told us monitoring took place in monthly one to one meetings.
- Induction and preceptorship was in place for new staff and staff spoke positively about this.
- Staff received monthly caseload supervision which included review of caseload weighting and individual performance against Key Performance Indicators.
- Staff received an annual appraisal from their line manager. Staff we spoke with told us they had received an appraisal however, the appraisal rate for non-medical staff in community health services for children,

young people and families was 73%. Information from the trust showed compliance rates in individual teams ranged from 28.6% (six out of 15 staff) in the Blackburn with Darwen CITNS team to 100% in the 0-19 South Ribble East team (19 staff) at April 2016.

- Staff told they used their appraisal to identify opportunities for training and development and while paid courses may not always be available, opportunities for shadowing other professionals had been arranged.

Multi-disciplinary working and coordinated care pathways

- We observed several examples of multi-disciplinary working during our inspection, with clinicians collaborating to support the planning and delivery of care to children, young people and their families. We observed a multi-disciplinary clinic at a child development centre which involved professionals from both the community and an acute trust working with the child and family to deliver a holistic and comprehensive service.
- The health visiting and school health teams worked closely together to support children and their families. If both a health visitor and school nurse were involved with a family the professional with most involvement would attend any multi-agency meetings and document the outcome in the electronic care records.
- Staff in the CTNS service were co-located and managed as a team. Joint visits were performed to children and families, for example an occupational therapist and speech and language therapist provided support to a child with feeding difficulties.
- The infant feeding team were commissioned to deliver the Baby Friendly Initiative and were supporting children's centres with their preparations for accreditation at the time of our inspection.
- We observed several school visits and observed effective communication between professionals. One Headteacher told us they had a very good partnership with the therapy services.

Referral, transfer, discharge and transition

- The management of a child's care moved from health visitor to school health when they entered school. The ECR allowed for timely transition of records and a health

Are services effective?

needs assessment questionnaire was offered to all Reception class children. A further questionnaire was also completed in year six prior to children transitioning to secondary school. The transfer of complex cases would be completed face to face by professionals and we observed this process during our inspection.

- Referrals to CITNS was by completion of a single point of access form which was sent to the referral and appointments centre. This was then triaged by professionals and appointments offered as required.
- Statutory health assessments were completed for all children who were looked after (CLA) and the CLA team managed the health assessments of children who did not have a health visitor or school nurse. Health assessments were quality assured by the named nurse for CLA.
- Paediatric liaison notified relevant services of children who had attended at emergency departments. The role of the duty health visitor included triaging all notifications as well as dealing with all transfer out requests to ensure prompt action.
- Families engaged with the FNP would move back to the universal health visiting service when their child reached the age of two years. The first families were due to be transferred in September 2017 and staff told us a model was being developed to support this transition.

Access to information

- Tablet computers allowed staff to access records while in clinic settings or during family visits. It also allowed staff in the CPOC team access to trust information when delivering care in a home environment.

- Policies and procedures were available to staff on the trust intranet and staff knew how to access them.
- The ECR allowed staff to access records from bases across the trust. It also enabled professionals to view appointments issued by other disciplines to determine attendance.
- We saw examples of the parent held child record ('red book') being completed in home and clinic settings.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- At our last inspection it was noted that staff in the vaccination and immunisation team were not always following the trust's consent policy in relation to Gillick competency. Since then the consent process had been changed and staff we spoke with were familiar with the new standard operating procedure.
- A good practice statement had also been written entitled 'Using Gillick Competence to Gain Consent for Immunisations in the School Setting'. This described how the use of the Gillick competence assessment was found to be a highly effective process and resulted in 51 students in a local school giving consent to receive immunisation. It was recognised that the process empowered students to take responsibility in relation to their health needs.
- A clinical audit of immunisation and vaccination processes in children was completed in June 2016 and demonstrated 100% compliance for the immunisation nurse carrying out a thorough check of the consent form before giving the vaccine.
- We observed where parent's consent was obtained to share information with the children's centre.

Are services caring?

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

Summary

We rated community health services for children, young people and families as 'Good' in the caring domain because:

- Staff treated children, young people and their families with kindness and respect both in person and during telephone conversations. NHS Friends and Family test results from the children and families network showed, in June 2016, from 419 returns, 95.4% of respondents would be likely to recommend the service to their friends and family if they needed similar care or treatment.
- Contacts we observed showed information provided to children and families was clear and tailored to the individual child. Families were offered choice regarding their child's care and given the opportunity to ask questions. Families engaged with the children's integrated therapy and nursing service (CITNS) were involved in writing their child's care plan.
- We saw many examples of positive interaction and provision of appropriate emotional support.

Compassionate care

- Staff treated children, young people and their families with kindness and respect both in person and during telephone conversations.
- NHS Friends and Family test results from the children and families network showed, in June 2016 from 419 returns, 95.4% of respondents would be likely to recommend the service to their friends and family if they needed similar care or treatment and 99% said staff treated them with courtesy and respect.
- In our last inspection we observed that, in a vaccination clinic, young people unable to roll up their shirtsleeves had to expose the top of their arms with only a gown to protect their modesty whilst in view of other young people waiting for their vaccinations. There were no immunisation sessions scheduled during our inspection, however, staff told us that a separate room

was now identified for children who would like a more private environment or who need to undress. This requirement was also documented in the standard operating procedure for immunisations within school.

Understanding and involvement of patients and those close to them

- Contacts we observed showed information provided to children and families was clear and tailored to the individual child. Families were offered choice regarding their child's care and given the opportunity to ask questions.
- Within the children's integrated therapy and nursing service (CITNS) parents were involved in writing their child's care plan.
- We observed a home visit to a family to discuss management of a care plan in school. This was to be signed by the parent, health professional and school to indicate involvement and agreement with the plan of care.
- As part of the inspection we asked parents, children, young people and those close to them to share their thoughts about the community service via the completion and submission of a comment card. The responses were positive and included the following comments, "School nurses have always been supportive of our young people; they are approachable and knowledgeable" and "lovely staff, very friendly and supporting".
- Parents and carers were routinely copied into letters following consultation with therapy staff and on discharge.

Emotional support

- We saw many examples of positive interaction and provision of appropriate emotional support. We observed a contact with a mother in a clinic setting who was offered a further home visit for additional support and advice.
- The complex packages of care team (CPOC) delivered care in patient's homes and worked in partnership with

Are services caring?

parents to support them to care for their child. The CPOC team also worked with hospice and outreach staff from acute trusts that provided palliative care to children in the community.

- We spoke with one parent who described accessing specific care that did not align to current health visiting advice. The parent stated, however, that she felt empowered to make her own decisions regarding her child and able to share the information with her health visitor.

- Health visiting teams signposted families to local children's centres and promoted contact with breastfeeding peer support workers to enable families to access additional information and support.
- We observed liaison between school health professionals and education staff to discuss particular issues with any child and identify any children that required individual contact with the school nurse.

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 community health services for children, young people and families as 'Good' in the responsive domain because:

- The children's integrated therapy and nursing service (CITNS) staff arranged joint visits to families to reduce the need for attendance at multiple appointments.
- Interpreting services could be arranged to support families whose first language was not English and link workers were available to interpret for families and practitioners in areas with highly diverse populations.
- The standard for referral to treatment times for paediatric therapy services was 92% of patients seen within 18 weeks. Referral to treatment times for physiotherapy consistently exceeded the standard of 92% since September 2015.
- From January to August 2016 referral to treatment times for occupational therapy consistently missed the 92% standard averaging 73% in this time period.
- From January to August 2016 referral to treatment times for speech and language therapy consistently missed the 92% standard averaging 89% in this time period.

Planning and delivering services which meet people's needs

- Staff and managers told us that a Local Authority Ofsted inspection published in November 2015 had a significant impact on the trust due to a number of complex cases being reassessed and managed under Child Protection plans rather than at a Child in Need level. School health staff told us in response to the additional workload they were working smarter and delivering interventions in schools in small groups rather than just in a one to one format.
- We spoke with senior teaching staff who valued the school health service and the special educational needs co-ordinator (SENCO) told us of the importance of school health in ensuring effective team working to meet the health and educational needs of children with complex needs.

- Children's Integrated Therapy and Nursing Service (CITNS) staff arranged joint visits to families to reduce the need for attendance at multiple appointments and parents told us that there was flexibility in the provision of appointments for children with complex needs.
- Health visitors in the West Lancashire area had returned to individual allocation of community clinics to promote continuity for families in response to service user feedback.
- Two year developmental review assessments were routinely performed in the home but could be arranged as a clinic appointment for the convenience of parents who worked.

Equality and diversity

- Interpreting services could be arranged to support families whose first language was not English and staff confirmed they knew how to access these however we did not see this in use during our inspection.
- Link workers were available to interpret for families and practitioners in areas with highly diverse populations and leaflets were available in a variety of languages.

Meeting the needs of people in vulnerable circumstances

- Home vaccinations were delivered by the immunisation team for families who were hard to reach.
- The Family Nurse Partnership (FNP) was offered in the Preston and Burnley area to first time mothers aged 19 years and under to improve health, social and educational outcomes.
- Health assessments for children and young people in residential care or who did not have an identified school nurse or health visitor were completed by the Children Looked After (CLA) team. The team also provided support for care leavers and engaged with social care to assist care leavers to access further education.

Are services responsive to people's needs?

- Safeguarding specialist nurses worked in partnership with other agencies to provide health assessment, advocacy and support for children and young people involved with the youth offending team or identified as being at risk of child sexual exploitation.
- Identified liaison health visitors were in post to provide support and advice to families placed in a refuge. Referral forms were in place to ensure timely information sharing between the refuge and the health visitor and if the family moved out of the refuge into the local area the named health visitor would remain involved to ensure continuity of care.
- A standard operating procedure (SOP) was in place to address failed contacts and disengagement in relation to children. This was to support practitioners to identify and follow up children and young people who may be vulnerable due to disengagement and lack of contact with services.
- Data supplied by the trust showed waiting times varied in each speciality, times also varied within teams at different geographical locations.
- Capacity issues relating to both occupational therapy and speech and language therapy were recorded on the risk register for community child health services and managers and staff acknowledged there had been pressures within therapy services. Performance was being monitored weekly by means of a patient tracking list and additional clinics had been arranged. Performance data showed the number of children waiting more than 18 weeks for speech and language therapy in August 2016 was 127 compared to 275 in July 2016. Similarly, the total number of children waiting over 18 weeks for paediatric occupational therapy was 78 in August 2016 compared to 90 in July 2016.
- Families were invited to opt in for an appointment with therapists; this limited the likelihood of missed appointments.
- Children who did not attend for an appointment were discharged unless there were additional considerations such as safeguarding concerns.

Access to the right care at the right time

- Health visiting teams delivered routine contacts as per the Healthy Child Programme and additional contact could be sought by parents in between. Well-baby clinics were also available for parents to access additional support and advice on a 'drop in' basis.
- The introduction of 'Chat Health' for children, young people and their families across the trust had increased ease of contact with school health. Enquiries were dealt with in a duty system and if not dealt with by return call, details were forwarded to the named school nurse for further contact, as required.
- The national standard for referral to treatment times for paediatric therapy services was 92% of patients seen within 18 weeks. Data from the trust showed that from January to August 2016 referral to treatment times for occupational therapy consistently missed the 92% standard averaging 73% in this time period.
- Data from the trust showed that from January to August 2016 referral to treatment times for speech and language therapy consistently missed the 92% standard averaging 89% in this time period.
- Referral to treatment times for physiotherapy consistently exceeded the standard of 92% since September 2015.

Learning from complaints and concerns

- A trust wide policy included information on how people could raise concerns, complaints, comments and compliments. Health visiting teams provided families with feedback forms at home visits which parents could complete and handback to the practitioner or send by freepost to the Patient Advice and Liaison Service (PALS).
- Information was displayed in clinics about how patients and their families could complain.
- Initial complaints were dealt with by team leaders in an attempt to resolve issues locally. If this was unsuccessful the complaint was escalated for further investigation.
- Staff we spoke with were aware of the complaints procedure and told us information about complaints was discussed in team meetings.
- Information regarding complaints was submitted monthly to the Quality and Safety Sub-committee.
- In the 12 month period 1 April 2015 to 31 March 2016, 38 complaints were received by community health services for children, young people and families.

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 community health services for children, young people and families as 'Good' in the well-led domain because:

- The risk register for community child health services included details of risks, the initial, current and target rating as well as corrective actions and review date. Managers we spoke with knew the risks and challenges to their service and shared this information with staff.
- The Clinical Director for the children and families network provided a monthly quality and performance report to the quality and safety sub-committee and performance was monitored against a variety of targets and data. Staff we spoke with were aware of the key performance indicators relevant to their role and individual performance was reviewed in monthly 1:1 meetings with their line manager.
- We observed strong leadership from team leaders and managers and staff spoke positively about the team leaders, describing them as visible, accessible and supportive.

Service vision and strategy

- The trusts vision was to provide 'High quality care, in the right place, at the right time, every time'.
- Staff we spoke with were aware of the vision and could describe the trust values of 'Teamwork, Compassion, Integrity, Respect, Excellence and Accountability'.
- The Strategic Plan 2014/19 underpinned the trust's vision and was made up of six priority areas including to provide high quality services, to provide accessible services delivering commissioned outputs and outcomes, and to innovate and exploit technology to transform care. All of which were applicable to the children and families network.
- Progress against the strategy was reviewed and monitored and included recognising challenges, opportunities and achievements.

Governance, risk management and quality measurement

- The risk register for community child health services included details of risks, the initial, current and target rating as well as corrective actions and review date. The three highest risks at the time of our inspection were in universal child health services, two of which related to quality and staffing within the school nursing service.
- Managers we spoke with knew the risks and challenges to their service and shared this information with staff.
- The Clinical Director for the children and families network provided a monthly quality and performance report to the quality and safety sub-committee. This ensured executive scrutiny of incidents, complaints and lessons learned as well as compliance with mandatory training and NHS Friends and Family test performance.
- Performance was monitored against a variety of standards and data included the National Child Measurement Programme (NCMP), referral to treatment times and vaccination and immunisation rates.
- Staff we spoke with were aware of the Key Performance Indicators relevant to their role and individual performance was reviewed in monthly one to one meetings with their line manager.
- Therapy staff in the CITNS service had job plans with an expected number of contacts per week.

Leadership of this service

- An organisational structure was in place for the children and families network led by a Network Director and Clinical Director.
- Daily management was delegated to team leaders.
- We observed strong leadership from team leaders and managers and staff spoke positively about the team leaders, describing them as visible, accessible and supportive.

Are services well-led?

- Monthly team meetings took place to ensure staff received information and feedback regarding incidents and complaints and were kept informed of developments within the trust.

Culture within this service

- There was a positive culture within children's services and we observed good team working in all the areas we visited.
- Teams were proud of the service they provided and how they worked together to support each other.
- Staff told us they felt listened to and described how, when some teams had been faced with a number of vacancies, service managers negotiated and consulted with service leads and staff to work out a solution.
- Monthly management supervision and review of caseload weighting ensured equity of workload and a hub model of working had been introduced to provide support across bases. Staff told us they felt connected to teams within their hub despite not being physically located together.
- One staff member told us, "I feel we have a quality service making a difference to children".

Public engagement

- The views of patients, children, young people and their families were actively sought within the service using the NHS Friends and Family test. Results for the children and families network in June 2016, showed that from 419 returns, 98% of respondents felt their views or wishes were considered in the planning and delivery of their care.
- Staff in the immunisation team used a tablet computer in school to obtain student's views and a parental survey had been trialled. In response to feedback from parents wanting information regarding the team and when they would be in school, an article had been placed in school newsletters with contact details.

- Comments, compliments and complaints forms were routinely provided to families following home visits to encourage feedback regarding the service, and as a result, allocated staffing had been implemented in community clinics to promote continuity of care.
- During our inspection health visiting and school nursing staff were planning to take part in a health promotion event within the local community alongside local sports groups, dance groups and businesses.

Staff engagement

- Staff received a weekly trust wide newsletter by email informing of organisational developments and attended monthly team meetings. A "Dear David" initiative was in place to allow staff to contact a member of the board directly to raise any concerns.
- Staff engagement events took place to capture staff views and annual staff awards took place to recognise work to improve experiences for service users and their families.
- In August 2016, the Family Nurse Partnership was decommissioned in Blackburn with Darwen. Staff involved told us how difficult the process had been due to the loss of the service and the speed of the decommissioning process.
- Physical and psychological support services were available to staff and staff were aware of how to access them.

Innovation, improvement and sustainability

- Evaluation of the 'Chat Health' programme was planned with a local higher education establishment.
- Speech and language therapists had devised a training and resource pack which had been sold to schools.
- A range of research projects were in progress in the children and families network including how to promote children's language development using family-based shared book reading.
- The good practice document regarding Gillick competence prepared by the immunisation team had been submitted to NHS England.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>How the regulation was not being met:</p> <p>Robust procedures and processes were not in place to ensure that safeguarding had the right level of scrutiny and oversight.</p> <p>This is because:</p> <p>The model of safeguarding supervision in use did not allow for objective, critical reflection of all current safeguarding cases.</p> <p>The safeguarding team were not copied into all referrals to Children's Social Care as per the trust policy resulting in a lack of oversight of safeguarding activity within the trust.</p> <p>HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 13 (1) (2)</p>

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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