

Isle of Wight NHS Trust

R1F

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)
R1F01	St Mary's Hospital		
R1FX5	Community Healthcare Services – St Mary's Hospital		







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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

We rated this core service as requires improvement because:

- Although staff knew how to use the electronic incident reporting system, staff across children's services did not always demonstrate a sufficient understanding of when to report an incident. The reported incident data supplied by the trust showed a significantly low number of incidents reported. There was no evidence to show learning from incidents was shared with staff.
- Key staff groups working with children and young people such as some children's therapy teams had not completed training in safeguarding children level 3. This did not meet the recommendations set out in national guidance.
- There was evidence to suggest the service was not meeting the needs of looked after children. Children and young people in care had a significantly higher 'did not attend' rate for clinic appointments and had a lower vaccination uptake rate. The emotional and behavioural needs of looked after children were not always taken into consideration when completing health assessments.
- There was a mix of electronic and paper medical records systems in place which led to duplication in records and staff could not always access important information in a timely manner. We highlighted this concern in our 2014 inspection report but no significant progress had been made to resolve this issue.
- Medicines were not always stored safely. In the school nurse base office, staff had consistently recorded the fridge containing vaccines as outside the maximum recommended range but had not taken any action to resolve this. In Medina House school we found three medicine cupboards in classrooms which were either unlocked or had the keys stored in sight.
- Nurses working in specialist schools were disconnected with the wider trust. Staff in the two specialist schools could not access the trust intranet, mandatory training or incident reporting system. The nurses did not receive clinical supervision and had not completed the specialist community public health nursing (SCPHN) qualification.
- The school nursing service had vacancies for nursing and support staff. Some staff were on secondment and additional cover for their roles had not been put in place.
- The trust did not provide mandatory training figures for all staff groups within the children and young people's community team. The compliance with some modules of mandatory training were significantly low, for example, health and safety and disability awareness.
- The children and young people's service did not have robust arrangement for measuring the quality and effectiveness of the service. Although the children and young people's service submitted some data to Public Health England and national audits, there were no local audit programmes in place for any of the services. Some teams such as the children's physiotherapy team collected a limited amount of data but this had not been collated and there was no evidence this had influenced quality improvement. .
- There was a trust wide clinical supervision policy, however staff told us there were no formal supervision arrangements in place for school nurses and health visitors to receive clinical supervision.
- Staff did not always seek consent in line with national guidance and legislation. The community children's nurses relied on assumed consent when delivering care and treatment to children and young people. The sexual and reproductive health service did not always record that consent to access services was assessed.
- The service did not always meet the individual needs of patients and their families. Information for children, young people and their families was written in English and not readily available in other languages. There was no age appropriate or specific pain tool in place for children or young people who could not verbalise their pain.
- Although the clinical business unit risk register contained some of the risks highlighted at a department level, there was no evidence to show these had been regularly reviewed and actioned. The children's service did not have a clear strategy in place to develop services and had not improved key areas identified in our 2014 inspection report.

However,

Summary of findings

- Staff had a good knowledge of how to recognise and escalate a safeguarding concern. Key staff groups valued clinical supervision provided by the safeguarding team. The trust had recently employed a specialist nurse for looked after children. The trust identified and provided targeted interventions for children and young people at risk.
- The service provided care underpinned by evidence and followed national guidance such as the National Institute for Health and Care Excellence (NICE). The health visiting and school nursing team met the healthy child programme and vaccination targets. The health visiting service had achieved the UNICEF Baby friendly breastfeeding initiative accreditation at level one.
- All services worked together to meet the needs of children, young people and their families. Therapy teams carried out joint visits to reduce the number of visits a child or young person would receive. The school nursing and health visiting team worked closely with other services such as the child and adolescent mental health team (CAMHS), Barnardo's, children's therapy teams and the sexual health service.
- There was evidence some staff had undertaken additional training appropriate to their role. Two school nurses had completed the SCPHN qualification and two more nurses had been seconded to complete this course. Health visitors had undertaken training in baby massage and prescribing nicotine replacement therapy.
- Some teams had shown evidence of innovation and improvement for example, the children's physiotherapy team had submitted a business case to provide a respiratory outreach service for children and young people. The school nursing and health visiting team had started to use a 'health bus' to hold clinics and health promotion events and had developed social media pages to engage with children and young people.

Summary of findings

Background to the service

Information about the service

The Isle of Wight NHS trust provides a range of community based services to children and young people on the island. Care is provided in a variety of settings including schools, health clinics, mobile clinics on the health bus and home visits. Services provided include health visiting, school nursing, community children's nursing service, community paediatricians, occupational therapy, physiotherapy, orthotics and speech and language therapy, sexual and reproductive health and end of life care.

The trust provides services to meet the physical, mental and psychological needs of children and young people aged 0-19 years. The inspection included the healthcare provision in two specialist schools: St Georges primary school and Medina House secondary school which cater for pupils with severe and complex needs such as learning difficulties, physical disabilities, medical conditions and autistic spectrum disorder.

Health visitor clinics are held in a variety of locations across the island including children's centres, GP surgeries and community centres. The trust did not own or manage these locations. The school nursing and

health visiting team have recently started using a health bus to provide mobile clinics and run health promotion events. The health visiting and school nursing team were managed jointly and formed the 0-19 service.

The trust provided a community children's nursing (CCN) team which provided support and respite care to children and young people who had life limiting illness. The team also provided end of life care to children and young people. At the time of our inspection the CCN team were supporting 50 children and young people with life limiting illness and providing respite care for eight children and young people.

Children form 20% of the islands 140,000 population. Child health profiles for the Isle of Wight showed the rate of child poverty was significantly worse than the England average with 19.2% of children under 16 estimated to be living in poverty. The rate of family homelessness was better than the England average meaning there were less families experiencing homelessness when compared to the national average. The Island has a higher teenage conception rate when compared with the England and regional average.

Our inspection team

Our inspection was led by Joyce Frederick, Care Quality Commission.

This inspection was carried out by two inspectors and two specialist advisors with experience in safeguarding, school nursing and health visiting.

Why we carried out this inspection

We carried out this short notice inspection of the Isle of Wight NHS Trust to follow up on some areas that we had

previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service or if we had not inspected the service previously.

Summary of findings

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?

We carried out a short notice announced inspection from 22 to 24 November 2016. During this inspection, we spoke with 31 staff including school nurses, health visitors, physiotherapists, community children's nurses and managers. We also reviewed 20 sets of records, spoke with 13 parents and carers and one young person. We

observed ten consultations and one parent craft session. We observed interactions between patients and staff, considered the environment and reviewed a range of management documentation and feedback from other agencies involved with the trust.

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

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment provided for children, young people and families in the community at Isle of Wight NHS Trust.

What people who use the provider say

We reviewed 11 responses from the children's physiotherapy feedback questionnaire and seven responses from the Bobath therapy questionnaire. All the responses from these questionnaires praised the care patients and their families had received from staff.

Children, young people and their families we spoke with told us they were treated with kindness and compassion by staff. Patients and families felt involved in decisions about their care.

Areas for improvement

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

Action the provider **MUST** take to improve

The trust must ensure:

- All incidents including near misses are reported in the children's community team and learning from incidents is shared across teams.
- All members of staff have access to the trust's information technology system to ensure they can access essential training and report incidents.
- Medicines are stored safely and securely in all locations.
- Patients' clinical records are not unnecessarily duplicated and staff have access to clinical records in a timely manner.
- All staff receive safeguarding training at a level appropriate to their role.

- The needs of looked after children are recognised and action taken to reduce the 'did not attend' rates amongst looked after children.
- Ensure health assessment for looked after children consider emotional needs and behavioural challenges.
- All staff complete mandatory training as required for their role.
- The school nursing service has adequate staffing to meet the needs of children, young people and their families.
- The children and young people's service develop an agreed set of quality metrics to measure the quality and effectiveness of the service on an ongoing basis. And there is ongoing improvement programme.
- Staff seek informed consent when carrying out all care and treatment

Summary of findings

- Staff record the ability for young people to consent to sexual and reproductive health treatment without a parent or carer present.
- That risks across the services are appropriately identified, assessed, escalated and managed. CBU risk registers should identify key risks in the services.
- All complaints are recorded and learning is shared with staff.
- The provision of formal supervision across the services is reinforced and made available to all staff.
- Implement the use of age appropriate pain assessment tools and pain assessment tools for children and young people who cannot verbalise pain.
- Make information for children, young people and their families available in other languages.
- Set up robust mechanisms for collating and taking action in response to feedback from children, young people and families.
- Improve mechanisms for recording and learning from informal complaints.
- Ensure nurses in specialist schools have appropriate qualifications if working independently.
- Undertake organisational development work and ensure all staff are feel part of and are committed to the vision and strategy for delivery of services

Action the provider SHOULD take to improve

The trust should:

Isle of Wight NHS 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

We rate safe as requires improvement because:

- There was inconsistency of incident reporting across children and young people's community services. Some staff did not report incidents through the trust's reporting system and some incidents were incorrectly classified meaning the appropriate action may not have been taken. The children and young people's service reported a lower than expected number of incidents. There was no evidence to show teams within the service shared learning from incidents.
- Not all staff were trained to the appropriate level for safeguarding children. School nurses in the special schools and some paediatric therapy staff had not received training in safeguarding children level 3.
- There were different medical records systems in place across the service which were not compatible. This led to duplication of records and some records not being available to staff. Although this had been highlighted in our 2014 inspection report and staff acknowledged this placed children and young people at risk, there was no action plan in place to address this.
- The recently employed specialised nurse for looked after children (LAC) had 250 children on her caseload which was more than double the national average.
- The did not attend clinic rate for looked after children was significantly higher than the national average. Although this had been highlighted as a concern, there was no action plan in place to address this.
- The temperature of the fridge storing vaccines in the school nurse base had been consistently recorded at above the maximum recommended temperature. Staff had not taken any action to resolve this or alert the pharmacy team.

Are services safe?

- Medicines were not stored securely in Medina House special school. We found three medicines' cabinets located within classrooms which were either unlocked or the keys were stored in sight next to the cupboard.
- School nurses based in special schools did not complete the trust's mandatory training as they had no access to complete it on the school site. Although the school nursing and health visiting team achieved the trust target of 75% for mandatory training, compliance was low in some modules such as health and safety and disability awareness.
- The school nursing team were understaffed at the time of our inspection due to existing and newly created vacancies and staff being seconded to roles in other areas of the trust.

However,

- Staff had a good understanding of how to recognise a safeguarding concern and respond appropriately. Staff had support from the safeguarding children team and received safeguarding supervision on a regular basis.
- The school nursing service had up to date patient group directions (PGD's) in place to allow nursing staff to administer vaccines. Batch numbers for vaccines were recorded on the child or young person's individual medical record.
- Staff told us they had access to equipment to meet the needs of children, young people and their families. Children and young people had access to equipment to promote their independence such as wheelchairs and frames.
- All the areas we visited were visibly clean and tidy. Staff adhered the trust's policy on bare below the elbow and followed the World Health Organisations five moments of hand hygiene to reduce the risk of cross infection.

Detailed findings

Safety performance

- The information provided showed 38 incidents had been reported from November 2015 to October 2016. The majority of these incidents were categorised as no harm (20) or minor harm (16). There was one incident categorised as major relating to computer issues and one incident categorised as moderate harm. Three of the incidents reported related to clinical issues.

- The information provided to us by the trust showed there had been no serious incidents in the community children and young people's service.
- The trust had not reported any 'never events'. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Incident reporting, learning and improvement

- The trust used an electronic incident reporting system. All the staff we spoke with knew how to use the system to report an incident. However, knowledge about incident reporting amongst staff across community services was not consistent. For example, a member of staff told us about a complaint from a parent when consent was not sought to give treatment which had not been reported through the trust's incident reporting system. Staff were not aware of incidents such as near misses which should be reported. This meant staff missed opportunities to improve and reduce likelihood of further more serious incidents occurring.
- The trust provided data showing the children's school nursing and health visiting team had reported 38 incidents from November 2015 to October 2016. Of these 38 incidents, 13 related to computer issues and five related to information governance or issues with medical records. There were three clinical incidents reported from November 2015 to October 2016 and the overall number of incidents was low for this type of service. This meant it was likely not all incidents were reported. The service had not identified this as a risk.
- Not all the incidents we reviewed were categorised correctly, for example we reviewed an incident where paper records were scanned into the wrong child's notes. This was categorised as an clerical error excluding medical records instead of an information governance incident. We observed another incident where staff had not recorded a birthmark on a baby's skin. The health visitor started safeguarding investigations as outlined in trust policy. The incident caused undue stress for the baby's mother. Staff reported the incident as a records error and not a clinical incident. This posed a risk that the service would not have an accurate view of incident trends in the service.

Are services safe?

- Staff could not always access the online incident reporting system in the community due to connectivity issues. School nurses working in special schools did not have any access to the incident reporting system and would need to go to the base office to report an incident. This posed a risk that incidents would not be reported in a timely manner. They told us that they would most likely report the incident through the school's reporting system as it was easier to do so which meant the trust would not be aware of any incidents occurring within these services.
- Staff told us they received individual feedback about incidents they had reported. However, this did not include themes of incidents or incidents which had happened in other areas of the community team. We reviewed nine sets of meeting minutes including health visitor team meetings, health visitor locality meetings and physiotherapy team meeting minutes. None of these showed discussions about learning from incidents or complaints had taken place.
- The trust had recently appointed a looked after children (LAC) nurse, as this was a recognised risk area. However they had 250 children on their caseload which was more than double the national average.
- The did not attend rate for looked after children (LAC) was 30% in October 2016 which was significantly higher than the overall average which was between three and 12%. A senior staff member told us this was a concern which needed to be addressed. However, there was no action plan in place to support this.
- The trust had a safeguarding children team in place to support all teams across the trust. All the children's community teams we spoke with knew about the service and how to access them. Staff told us they valued the support and guidance from the safeguarding children team.
- Staff we spoke with across all children's community services were able to recognise safeguarding concerns for children and young people. They showed a good knowledge and awareness of the safeguarding processes and their responsibilities in protecting children and young people from harm. We observed health visitors in clinics assessing children's skin and parental interaction in line with the trust's safeguarding policy. All staff we spoke with told us they were able to access safeguarding advice when required and knew how to report any safeguarding concerns.
- The training data for safeguarding children showed that compliance with training was variable across teams. For example the school nursing and health visiting team achieved 100% compliance for level 1 and two safeguarding children training. However, other teams had significantly lower compliance for example the sexual health service achieved 33% compliance and the physiotherapy team achieved 54% compliance with safeguarding level two training. The orthotics and prosthetics services only achieved 6% compliance with safeguarding children level 2 training. This posed a risk that staff may not be able to recognise safeguarding concerns and take action as needed.
- Not all staff across the children and young people's community team held the correct level of safeguarding children training. The safeguarding children and young people: roles and competences for health care staff, intercollegiate document, March 2014, defines required level of safeguarding for a variety of staff groups. The document states all clinical staff working with children, young people and/or their parents/carers and who

Duty of Candour

- The Duty of Candour is a regulatory duty that relates to openness and transparency legislation and requires providers of health and social care services to notify patients or other "relevant persons" within a reasonable time. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Staff were aware of their responsibilities to be open and transparent. The health visiting teams were aware of the duty of candour and their responsibilities in evoking this. Other staff, including some managers were not aware of the duty of candour and were unable to give an example where the duty of candour had been initiated. The trust did not provide evidence that the duty of candour was being applied.

Safeguarding

- There was a safeguarding children's team which had one vacancy and had demanding workload, particularly with the number of reviews required from the multi-agency safeguarding hub (MASH). The team also provided training and children's safeguarding supervision.
- The training data for safeguarding children showed that compliance with training was variable across teams. For example the school nursing and health visiting team achieved 100% compliance for level 1 and two safeguarding children training. However, other teams had significantly lower compliance for example the sexual health service achieved 33% compliance and the physiotherapy team achieved 54% compliance with safeguarding level two training. The orthotics and prosthetics services only achieved 6% compliance with safeguarding children level 2 training. This posed a risk that staff may not be able to recognise safeguarding concerns and take action as needed.
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Are services safe?

could potentially contribute to assessing, planning, intervening and evaluating the needs of a child and parenting capacity where there are safeguarding or child protection concerns should complete safeguarding children level 3 training. The health visiting and school nursing team achieved 87% compliance for safeguarding level 3 training which met the hospital target of 75%. However, school nurses in the specialist schools and the children's therapy team had not completed safeguarding level 3 training. We received conflicting information regarding safeguarding children level 3 training for staff in the sexual health service. Data provided by the trust after our inspection showed none of the nurses in the sexual health team had completed level 3 safeguarding children training. In March 2017, the trust told us 89% of nurses working in the sexual health service had completed level 3 safeguarding children training at the time of our inspection but this had not been represented on the trust's system. However, the data provided by the trust in March 2017 did not specify which training had been completed. This posed a risk that staff would not recognise or escalate safeguarding concerns appropriately.

- The safeguarding children team told us it was sometimes difficult to ensure compliance with multiagency level 3 safeguarding children training due to a lack of spaces on the local authority led sessions. The trust had implemented a number of initiatives to resolve this including organising their own sessions with guest speakers such as the police.
- Health visitors, school nurses and the sexual health team had a good knowledge about child sexual exploitation. The sexual health service nurses working with young people attended the missing, exploited, trafficked adolescents and children (METAC) meeting. This was a multi-agency meeting attended by police, a recognised children's charity and the child and adolescent mental health service (CAMHS). This meant the sexual health service could raise concerns for example about individuals who had accessed the service.
- School nurses, health visitors and the children's therapy teams received safeguarding supervision with the safeguarding children team every two months. This allowed staff to discuss safeguarding cases and reflect on their practice. The children's community nurses did not receive safeguarding supervision.

- The National Health visiting service specification 2014/2015 states that Health visitors (HVs) must receive a minimum of three monthly safeguarding supervisions of their work with their most vulnerable babies and children. These should include children on child protection plans, those who are 'looked after' and not in residential care and those for whom the health visitor had a high level of concern.
- The manager of the school nursing and health visitor team was invited to debrief after any serious case reviews. They told us this allowed an opportunity to discuss learning and take back messages to the team. However, we did not see any evidence of how this was cascaded to the team.
- School nurses and health visitors told us they attended all child protection conferences. The trust provided data showing the school nursing and health visiting team had attended 34 case conferences and an additional 5 which had been attended by both a school nurse and health visitor. Staff told us this worked well when they had capacity but were concerned the staffing levels were not sustainable.
- The school nursing team were aware of children and young people who may be at risk but not visible, for example, children who were home educated and students from overseas. School nurses worked with social services to ensure these children were safeguarded. The school nursing service was currently recruiting an additional band six nurse to take the lead for home educated children.
- The trust had an up to date safeguarding children policy dated which gave clear guidance on what action to take. Guidance in the policy set out that if staff had safeguarding concerns about a child there was a process of identifying the concerns, and assessing the risks. If a protective plan was needed then other support could be provided for children before a referral to children's social care was actioned.
- Records for children and young people were a mix of electronic and paper records. Staff told us when writing a report for a child protection case conference they would need to access information from two different electronic systems, paper records and for some services contact them by phone. Staff told us this was time consuming and posed a risk that a service could see a

Are services safe?

child and no-one else would know. This posed a risk that important safeguarding information could be missed. Staff told us the time taken to write a report would range between a few hours and one day.

- Staff told us issues with duplication and different record systems had been highlighted consistently in serious case reviews but this had not been addressed by the trust.
- Health visitors could not access records for children who were aged 5 and above due to a firewall on the electronic patient records system. A health visitor gave us an example of when she had visited a young child on her caseload but had concerns about the child's older sibling. The health visitor was unable to access the older child's record and had to break through the electronic firewall to access the information. This was called 'breaking the glass'. All the staff we spoke with across the health visiting and school nurse team told us this was a problem and delayed them in accessing important information, and that this could impact on children's care and their welfare.

Medicines

- Vaccinations kept in the fridge at the school nurse base office were not kept within the recommended temperature. We reviewed the fridge temperature documentation record that showed from 27 October 2016 to 24 November 2016 the fridge temperature had been consistently recorded as 13 degrees celsius and no action had been taken. This was outside of the recommended range of two to eight celsius. The efficacy of medicines stored outside the recommended temperature could be adversely affected and may not have been safe for use.
- There was a system in place to transport vaccines from the base office to clinics. Vaccines were checked out by two members of staff and transported in a cool bag with ice packs which kept the vaccines cool for six hours.
- Health visiting teams ensured the safe storage and preservation of the 'cold chain' was consistently managed. The "cold chain" is a system of storing vaccines within a recommended temperature range to ensure they maintain their efficacy. Staff in the schools maintained a log which showed the fridge temperatures were checked daily.
- Batch numbers for vaccines were recorded on patient record cards kept by the child or young person and also recorded on their electronic record.
- There was a patient group direction (PGD) in place for school nurses to administer the human papilloma virus (HPV) vaccine. The HPV vaccine is usually given to girls aged 12-13 years old in schools in England to protect against cervical cancer. A PGD is a written instruction for the supply and / or administration of a named licensed medicine for a defined clinical condition. Their use allows health professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health professional working within the PGD is responsible for assessing that the patient fits the criteria set out in the PGD.
- Medicines were not stored securely in Medina House special school. Each classroom had a small medicine cabinet. We visited three classrooms. In two of the classrooms, the medicine cabinet was locked but the keys were stored in the lock or bedside the cabinet. In one classroom we visited the medicine cabinet was left unlocked. This was unsafe as medicines could be accessed by unauthorised people.
- Fridge temperatures in Medina House school and St George's school were recorded daily and within the acceptable range.
- Teaching staff administered medicine in Medina house school. All medicines were checked by two members of staff. Teaching staff held competency assessments completed by the nurse, this included oral medications, gastrostomy medicines , inhalers, creams, insulin and emergency drugs to treat seizures.
- The school nurse at St Georges school administered medicine for children and young people. However, if the school nurse was not on site, two members of teaching staff brought the child to the nursing office and administered the medication. Teaching staff told us they had completed competencies in medicines administration but this was not formally recorded. We observed the nurse administering medication to a number of children, this was recorded on their paper record and double checked by a member of teaching staff. Consent to administer medicines in school had been given by parents. All medicines had to be labelled by a pharmacy with the child's name. We checked all the medicines held in the medicine cabinet and all were labelled appropriately.
- St George's school held controlled drugs for children and young people. Storage and administration of these

Are services safe?

medicines were recorded on a separate sheet. This included the name of the medicine, quantity received, quantity returned, expiry date and signature. These medicines were stored in the same medicine cabinet which was in line with guidelines for medicines in schools.

Environment and equipment

- Health visitor clinics were held in a various locations such as family centres which were not owned by the trust. However, staff ensured there were adequate facilities for children and families such as a separate room to hold private conversations, age appropriate toys and disabled parking.
- Health visiting staff said they had enough equipment to deliver care. We observed sets of weighing scales and found they were all up to date and calibrated annually .
- At the schools we visited, staff confirmed children were provided with and had appropriate equipment to meet their needs. These included wheelchairs and adapted frames to support and maintain children's independence. We saw a variety of equipment was available to children at all the schools we visited and these were in good condition.
- At the clinics we visited, there were appropriate arrangements for the management of waste, including clinical waste and sharps.
- Staff were provided with mobile phones and laptops. Staff were able to access desk top computers or docking stations at their bases and told us there was enough office space.

Quality of records

- The trust was using different systems for patients' records which staff consistently told us were not compatible. At the time of the inspection, patients' records were held on two different electronic systems and in paper formats. Some teams such as the therapy staff did not have a facility to record current and previous family notes electronically. Other records such as ophthalmology and the CAMHS were paper records which could not be scanned onto the system as the office did not have a scanner. If needed by another team, staff would post these records to the relevant team.
- The health visiting and school nursing teams used an electronic patient record system. The children's therapy team and sexual health service used paper records. Staff

told us a child aged under five could have four sets of medical records, an electronic record, a family record, a paper record and a safeguarding record held by the safeguarding team. This posed a risk staff did not have all information they required to provide care and treatment to the child. The multiplication of records was on the risk register, however, there was no action plan to show how this was being addressed.

- The children's community nursing team kept paper clinical records of children's care and treatment and did not use the trust's main electronic recording system. However, the same team recorded their activity on a different system which did not link to the paper records or the trust's main system. Therefore, all children using the community nursing team had two sets of records for this one service which did not link to the trust's main record system.
- Health visitors in some clinics had to record notes on paper and wait to go back to the office to add to child's notes due to IT connectively failing. Staff told us that they would try and add information on the same day but this was not always possible if a clinic finished late. We saw where this had been reported as an incident as this could have impacted on the service children and young people were receiving.
- Health visitors recorded in the parent held child health record (PCHR) or 'red book'. Parents were encouraged to bring their child's PCHR to every clinic appointment. These were available in all the clinics we observed. We reviewed eight children's PCHR and all were completed appropriately. However, we saw a record where the child and mother's details had not been recorded.
- We reviewed all incidents reported by the health visitor team. One incident described a baby's birthmark, which had not been recorded in their PCHR. The member of staff followed the bruising in non-mobile babies protocol as per trust policy. However, this caused undue stress for the new mother due to a lack of accurate records.
- Staff told us about an incident where a child's paper records were scanned into another child's electronic record. The service manager told us they had shared this with the team to ensure information was checked before scanning. However, there were no audits to assess the accuracy of information.

Are services safe?

- We reviewed 12 sets of records including health visitor, school nursing, community nurse, sexual health and physiotherapy records. All the records we reviewed were completed in sufficient detail to support safe care, legible and all entries were signed and dated.

Cleanliness, infection control and hygiene

- All the locations we visited were visibly clean and tidy. We observed staff followed the trust's 'bare below the elbow' policy. This allowed for effective handwashing and reduced the risk of cross contamination. The majority of staff we observed followed the World Health Organisations five moments of hand hygiene. However, we observed one member of staff who administered medicine and did not wash their hands before or after doing so.
- School nurses told us they had access to handwashing areas and hand sanitiser in schools where they carried vaccines. We saw school nurses had provision of personal protective equipment such as gloves to take to schools and home visits.
- Community teams had a hand hygiene champion and carried out yearly hand hygiene training with the team using practical methods such as a lightbox showing how well staff had cleaned their hands. The trust provided records to show six members of staff from the children's speech and language team had attended this training.
- The trust provided hand hygiene and infection prevention and control training (IPC). There was variable compliance with this training among staff groups in the children and young person's community team. Data provided by the trust showed 6 out of the 18 staff groups identified in the children's community team did not meet the trust target of 75% for IPC training. Nine out of the 18 groups did not meet the 75% target for hand hygiene training.
- All the equipment we observed was visibly clean. We observed the majority of staff cleaning equipment in between patients. However, in one clinic we a child urinated on a mat. The staff used a wipe to clean the mat but did not use soap and water.
- None of the community children's services carried out hand hygiene audits to assess staff handwashing in practice. This meant there was no ongoing assurance that staff were washing their hands in accordance with best practice guidance.

- All clinics and consulting rooms had toys available for children to play with whilst awaiting their appointment and there were toy cleaning schedules in place. Staff used sanitising wipes to clean toys in between patients.

Mandatory training

- The trust provided online and face to face mandatory training. Mandatory training included information governance, safeguarding children and adults, equality and diversity, health and safety, conflict resolution and infection control training.
- Data from the trust for November 2016 showed that the school nursing and health visiting team achieved an overall 79% compliance with mandatory training which met the trust's target of 75%. However, some modules had a low compliance rate for example disability awareness (66% compliance) and health and safety (58% compliance).
- Nurses working in the special schools were out of date with the trust's mandatory training as there was no facility to complete it on the school site. The nurses told us they completed mandatory online training from the school as they could not access the trust's online training but this did not provide the assurance they had been trained in the areas the trust had deemed as essential in ensuring minimum safety standards in their practice.

Assessing and responding to patient risk

- The trust used the Healthy Child Programme to identify and support children, young people and families according to their level of need. The levels of service used depended on need and the risk of harm. The trust had arrangements in place to coordinate and support these children and their families and meeting their needs.
- There was more targeted support such as the universal service, the universal plus, for those requiring a brief period of extra support and the universal partnership plus, for families requiring intensive support involving other professionals.
- Assessments were recorded in a timely way. We saw a range of records across children's services, for example, risk assessments were completed. The trust had policies and pathways for staff to use when certain risks were identified, for example, domestic abuse and child sexual exploitation. Staff knew how to identify when children required more specialised services and referred them

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appropriately. However, due to the different patient record systems in place throughout children's services there was a risk not all information would be available to draw appropriate conclusions about the risks presented.

- Where risks such as choking were identified, assessments and referrals were made appropriately to ensure the child or young person's safety.
- The school nurse at St George's special school held an emergency salbutamol inhaler for children and young people with asthma. This was in line with department of health (DOH) guidelines on the use of emergency salbutamol in school. Patients had individual consent forms and the nurse had received training on how to administer salbutamol.
- In Medina House special school, we saw staff respond in timely way to changes in children's conditions. For example, we observed the school nurse advising about changes in a child with complex needs breathing patterns and the same nurse advise the education staff on appropriate management of changes to another child's bowel habits. All children at this school had a health care plan which outlined potential patterns of deterioration and the required responses.
- We reviewed seven care plans at St George's school, five of these were in date. Two of these care plans had not been reviewed since 2014, this posed risks of children receiving inconsistent or outdated care and not according to their current needs. We raised this with the nurse at the time of the inspection who recognised this and told us this would be completed.
- The paediatric occupational therapy team provided a community based service for children and young people from 0-19 years. They accepted referrals for children and young people with a physical disability or significant physical impairment or a confirmed diagnosis of autism spectrum disorder (AUD). The OT teams used a traffic light system to ensure that children who had safety needs such as behaviour which was unsafe or dangerous to themselves or others were seen as priority.
- The school nursing team had vacancies due to new posts for a team lead and three community nursery nurses. The service also had existing vacancies for one support worker and one band six nurse. At the time of our visit two school nurses were seconded to complete an additional qualification..
- The school nursing team caseloads varied in each locality. The west and central locality had three senior school nurses, one school nurse and one support worker to cover two secondary schools and 15 primary schools. The South Wight team had two senior school nurses, one school nurse and one support worker to cover three secondary schools and 12 primary schools. The North East team had the same staffing as the South Wight team and two secondary schools and 13 primary schools. There are no national guidelines outlining recommended caseloads for school nurses. However, team meeting minutes showed some areas were considered short staffed as staff were seconded into other roles. The reduced staffing and increase in child protection work had been included on the risk register.
- The children's community nursing (CCN) team had one vacancy for ten hours per week. The CCN team had two team leaders, three senior nurses, one nurse for 15 hours and 3 full time community nursery nurses. At the time of the inspection the CCN team were caring for 50 families with life limiting illness and eight children were receiving respite care.
- The lead for the school nursing and health visiting teams had put in a proposal to manage the budget for health visitors and school nurses jointly to allow an adequate skill mix across the service as a whole.
- In our 2014 inspection, we identified concerns there was only one member of full time staff within the school nursing service. The team had resolved this and now provided all year round cover with three nurses and two support workers.
- We requested staffing and caseload information from the children's therapy teams; however, the trust did not provide this information.

Staffing levels and caseload

- There were no vacancies in the health visiting team at the time of our inspection. Caseloads were calculated depending on the vulnerabilities and needs of the population in each locality. The caseloads ranged from 168 children per full time health visitor to 260 children.

Managing anticipated risks

- All children's community teams had a lone working policy in place. Teams operated a weekly rota system where one member of staff was responsible for ensuring all lone working staff had phoned to state they were safe at the end of the working day. The member of staff responsible would check messages at the end of the

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day to ensure all staff were safe. If staff had not left a message the member of staff on duty would attempt to contact them and their next of kin if they did not answer. If the member of staff had not arrived home safely there was an escalation policy to follow. However, staff in the health visiting teams told us that due to the connectivity of the IT systems they could not always access the voicemail. This had been reported to IT three weeks prior to our visit but no contact or resolution had been made.

Major incident awareness and training

- The school nursing and health visiting team had business continuity plans in place. Staff were aware of these plans and gave us examples, such as in bad weather they were relocated to work at the base closest to them. If IT failed they would revert to paper records.

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.

We rated effective as requires improvement because;

- There was a lack of clinical audits across all the community children's teams. We raised this issue in our 2014 report; however, no significant progress had been made to resolve this.
- Nurses in specialist schools did not hold public health qualifications and were working independently with minimal supervision.
- There was a trust wide clinical supervision policy, however staff told us there were no formal clinical supervision arrangements for school nurses and health visitors.
- There were no age appropriate or specific pain tools available to assess children who could not verbalise their pain.
- Data submitted to the British Association for Sexual Health and HIV showed 18% of staff did not document young people's ability to consent to sexual health advice or treatment without a parent or carer present. This was higher than the England average.
- The children's community team did not record if verbal or written consent had been obtained before carrying out care or treatment.
- The immunisation rate for children in care was lower than the England average. Data from Public Health England showed 81.5% received the first dose of MMR, DTAP and HIB vaccine against the national average of 87.8%.
- Only 20% of health assessments for looked after children considered additional health needs such as emotional or behavioural problems. This meant the majority of looked after children did not receive a holistic assessment of their needs.
- Mothers were sufficiently supported to breastfeed and breastfeeding outcomes were in line with national averages.
- Staff assessed children's nutritional needs and referred them to specialist teams for advice and support.
- The community nurses worked collaboratively with the local hospice in supporting children, young people and their family in providing end of life care.
- Children were supported by the children's therapy team through the use of assessment tools and outcome measures.
- The health visiting team met immunisation targets for childhood immunisations and the uptake of the human papilloma virus (HPV) vaccine was better the national average in year eight and year nine girls. Two school nurses had completed the specialist community public health qualification (SCPHN) and another two nurses were on secondment working towards this qualification. This was an improvement from our 2014 inspection report.

Evidence based care and treatment

- There were a number of policies and procedures and national guidance which staff followed to provide evidence based care and treatment. The children community nurses used National Institute of Health and Care Excellence (NICE) guidelines to support children, young people and their parents. Some of these included NG61 'End of life care for infants and young people with life limiting conditions' and NG18 'management of diabetes types 1 and 2 in children and young people'.
- The health visiting teams used the Ages and Stages Questionnaires (ASQ-3), as part of the Health child programme specification (HCP 2) as set out by NHS England in 2015. Data from public Health England showed 98.8% of children aged between two and two and a half years old received their review using the questionnaire. We saw these were completed by parents and covered five domains of child development. These included communication, gross motor skills, fine motor

However,

- Staff delivered care and treatment in line with best practice guidelines. These included National Institute for health and Care Excellence (NICE) and Department of Health guidelines.
- The health visiting team met the five review stages of the healthy child programme and submitted data on a quarterly basis to public health England.

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skills, problem solving and personal-social development. This also provided guidance for health visiting teams and follow up actions they should take when any concern was identified.

- The healthy child programme had been developed to support the development and improving the health and well-being of children and young people. This was a collaborative way of working where health visitors led the 0-5 service and the 5-19 was led by school nursing services. We saw evidence the Healthy Child Programme for children aged 0-19 had been implemented. This included immunisations, screening and National Child Measuring Programme.
- The health visiting service had achieved UNICEF baby friendly initiative (BFI) and World Health Organisation (WHO) stage 1 baby friendly initiatives (BFI) breast feeding accreditation. This is an evidence based approach to support breastfeeding by improving standards of care and support. The trust told us all health visitors had been trained in the baby friendly initiative. However further development was needed in order to achieve stage 3 final BF1 accreditation.
- We observed clients being supported emotionally. A maternal mood review was offered postnatally to assess emotional wellbeing of new mothers following childbirth. Nationally 10% to 15% of all postnatal women will suffer from mild to moderate depression with the majority being supported by their GP and health visitor.
- The trust provided data to show compliance with maternal mood assessment. However, this was dated January 2015 and outside the reporting period for this inspection.
- The school nursing team had recently undertaken training in cognitive behaviour therapy to support young people. The service had also introduced a questionnaire which had been designed with the child and adolescent mental health service (CAMHS) to assess the mental health of children and young people.
- The occupational therapy (OT) team had implemented the Canadian Occupational Performance Measure (COPM) which was adapted for use with children, young people and their parents. The purpose of the COPM helped develop goal orientated and patient-centred OT intervention.
- The physiotherapy team used the Oxford postural management assessment for all children with complex physical disabilities. There is evidence to suggest this

improves outcomes for children requiring postural support. We saw a written record using Oxford Postural assessment tool and attached care plan with predicted outcome goals.

- Managers told us national guidance for example from the National Institute of Care Excellence (NICE) was implemented into care pathways by the pathways group. The manager for school nursing and health visiting was currently reviewing the care pathways for school nursing. This had been discussed at the practice development group meeting held with school nurses and health visitors.
- The continuing care team provided comprehensive packages of care to patients with complex needs and these were reviewed at regular intervals.

Nutrition and hydration

- The trust had achieved stage 1 accreditation for breast feeding initiatives. We observed staff provided support and advice on breast feeding. This formed part of the discussion with mothers when they attended the drop in clinics.
- Parents told us they were able to ask for advice on breast feeding; although two parents told us that this was not well promoted in the maternity units.
- The trust submitted data to Public Health England in relation to the number of babies breastfed at six to eight weeks after birth. Data provided by the trust from July 2016 to September 2016 showed 45% of babies were either fully or partially breastfed at their six to eight week check. This was in line with the national average of 44%.
- Health visitors told us that some breast feeding support groups were in place with and breastfeeding peer support groups in the community. There was an identified lead midwife who was available to provide advice and support to mothers with complex breastfeeding problems.. Health visitors were able to refer mothers to specialists such as dieticians and the speech and language therapy teams for advice about breastfeeding and dietary concerns.
- The paediatric speech and language therapy (SLT) teams were also involved closely in the care and management of children who had additional feeding and drinking needs. During one of the clinics we saw that a referral was initiated to the SLT team following discussion with the parent for further assessments and advice.

Are services effective?

- Data from the child health profile showed that children on the Isle of Wight had an average rate of obesity. In Children aged four to five years old, this was at 9.1% and 20.5% of children aged 10 to 11 years old were classified as obese which were in line with national averages. Staff we spoke with were not aware of any initiatives within the trust to address obesity in children.

Pain relief

- Community paediatric physiotherapists were independent prescribers and could titrate medicines for children with physical, behavioural and learning disabilities. We observed the physiotherapist adjusting the dose of a medicine to reduce muscle spasm for a physically disabled child.
- We observed a child at a special school who had fallen during break time. The nurse assessed the child's pain asking them to describe the pain and point to where it was hurting. The nurse explained to the child why their back was hurting and administered pain relief. However, we did not see any age appropriate pain tools or tools for children and young people who could not verbalise their pain in use in any area of the service. Without the use of a standardised pain assessment tool, the assessment of pain can be variable and pain management can be inconsistent.
- Children attending special schools and requiring regular pain control medicines brought these into school in a labelled box dispensed by a pharmacy. Pain control medicines were administered during the school day as required by the school nurse or two classroom assistants.
- The community nursing team told us they did not prescribe medicines, they would refer the children and young people to their GP.
- Children and young people receiving end of life care received appropriate support to manage their pain which included anticipatory medicines. The local palliative care and children's community team teams sought advice and support in regard to pain control from children's hospices on the mainland.

Technology and telemedicine

- Community staff had been issued with laptops to record care given to children and young people during, or immediately after, home visits.

- The trust's website contained some information; however these were not designed to meet the specific needs of children. For example health information about health matters for children and young people had not been developed.

Patient outcomes

- Incident data provided by the trust showed there were no deaths of children and young people reported in incident reports.
- The health visiting team met the five review stages outlined in the Healthy Child Programme (HCP). The Healthy Child Programme stipulates that a new baby review should take place by 14 days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding and how to reduce the risks of sudden infant death syndrome.
- The health visiting service performed better than the England average for completing screening visits in line with the healthy child programme. From June 2016 to September 2016, the service saw 100% of babies born within 14 days for a new birth visit (NBV) compared to the England average of 88.5%. The service completed 92% of babies six to eight week check by the time they were eight weeks old compared to an England average of 81.9%. The health visiting team completed 93% of babies' 12 months' reviews by the age of 12 months and 99% of 2 to 2 and a half year old reviews in the same time period. This was significantly better than the England average of 75% and 78% respectively.
- Public Health England (PHE) data showed that the rate of alcohol-specific hospital stays among those under 18 was 81% which was worse than the average for England.
- The breast feeding data for the Isle of Wight showed that the percentage of mothers' breast feeding at initiation (within 48 hrs) had fallen from 81% to 74% in 2014/15 survey which was updated in September 2016. This was different to the national trend which showed mothers breastfeeding at initiation was increasing. Locally, there were inequalities in breast feeding prevalence within 48 hours rates which varied between 96% to lowest rates at 52% depending on the geographical location of the mother. Similarly, mothers who were living in the most deprived areas were less likely to continue breastfeeding beyond six to eight weeks. .

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- The prevalence of women smoking at delivery was higher than the national average of 11% and this was higher in younger mothers.
- The children immunisation rates for measles mumps and rubella (MMR), diphtheria, polio, tetanus, pertussis (Dtap) and Hib was in line with England average. PHE data showed that 92% had received one dose at 2 years, and 94% had received Dtap, IPV at 2 years. However for children in care the rate was 81.5 % which was lower than England average of 87.8%.
- The uptake rate for the HPV vaccine was higher than the England average for both year eight and year nine girls. Data from Public Health England from September 2015 to August 2016 showed that 92.9% of year eight girls received at least one dose and 90.2% received two doses. The England average was 87%. For year nine, 100% of girls received at least one dose compared to national average of 90.2% and 99% of girls received two does against a national average of 85%.
- The community therapy teams did not have a clinical audit plan in place and had not carried out any clinical audit. The lead for the service told us they were planning to introduce an audit programme but there were no specific plans in place to achieve this at the time of our inspection.
- Although the school nursing and health visiting teams submitted data in relation to the healthy child programme to Public Health England, they did not have a robust clinical audit plan in place. This was highlighted in our 2014 inspection report but no significant progress had been made to resolve this.
- The looked after children (LAC) audit report for initial and review health assessments completed in August 2016 showed that only 60% of children and young people had a full assessment of their emotional needs as a result of being a looked after child. Only 20% of looked after children received an assessment taking into consideration additional health needs such as emotional or behavioural problems. The audit highlighted this was an area which needed improvement.
- Following the national perinatal audit, there were a number of recommendations made and the trust updated their action plan in July 2016. This included that all still births and neonatal deaths were offered a post-mortem. Data was reported to Mothers and babies:

reducing the risk through audit and confidential enquiries across the UK (MBRRACE-UK) about mothers who change providers during pregnancy and following delivery so that they could be followed up.

Competent staff

- All staff new to the organisation underwent a corporate induction in addition to a local induction when they joined the trust.
- Staff across all services told us they received yearly appraisals, which were values based and assessed staff behaviour as well as clinical competency. The staff we spoke with were positive about the appraisal process and told us they discussed what they wanted to achieve over the next year and set realistic objectives.
- Information provided by the trust showed that the health visiting teams had achieved compliance with an appraisal rate of 100%. Senior managers told us there was a rolling programme in place to ensure staff received appraisals. Further data received from the trust indicated there was variation in appraisal rates for example paediatric speech and language therapists achieved a compliance rate of 83% and none of the seven community practitioners had received an appraisal.
- All newly qualified staff in the community were offered a preceptorship period of six months. During this time they were supported to develop their confidence, skills and professional competencies and would be working under supervision.
- Health visitors and school nurses could access additional training. This included cognitive behaviour therapy (CBT) essential skills, infant massage, and nicotine replacement for Health visitor prescribers. Staff spoke positively of the training opportunities available to them.
- The community nursing team had completed training in end of life care and used the competency framework for nurses. The competencies were reviewed yearly at appraisals. The nurses also used networking with the palliative care teams in Dorset, Southampton, Poole and Salisbury as part of their learning and developing their skills and knowledge.
- The community nurses also worked closely with the children's hospice on the mainland for oncology service and consultants' advice on symptom management. This

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included scheduled meetings and staff were able to contact the service for advice and support regarding pain control for children and young people receiving palliative care.

- Some health visitors took part in practice events on the mainland and in the community. These were professional events for health visitors to share good practice, with colleagues on the mainland. One health visitor told us, 'it is a good opportunity to keep up to date as you can be isolated on the island sometimes.'
- Two school nurses had completed the specialist community public health nursing (SCPHN) and two nurses were on secondment at the time of our inspection to complete this. This was an improvement from our 2014 inspection report where no school nurses held this qualification. The manager of the school nursing service told us they were planning to develop a preceptorship programme to support school nurses who had recently completed the SPCHN training.
- Nurses in special schools did not hold public health qualification and were working alone with minimal supervision and support from the school nursing team. We raised this with the manager of the team who told us they would address this issue.
- The school nurse at Medina house school provided teaching and competency assessment for teaching staff. This included subjects such as healthy eating, managing constipation and administering a feed via a tube. The school nurse had undertaken additional training such as supporting pupils at school with medical conditions and prescription training. The school nurse at St George's had undertaken additional training for example in sexual health and safeguarding for children with disabilities.
- There was a trust wide clinical supervision policy in place. Health visiting and school nursing teams told us there was no formal arrangement for clinical supervision. The manager of this service told us they were developing a clinical supervision programme for all school nurses and health visitors. Although this had not been introduced at the time of our inspection, locality leads and staff knew the programme was being developed.
- The school nursing and health visiting team held a monthly professional development meeting. This included updates on referrals, new ways of working, recruitment and teaching sessions. Staff told us they valued these meetings and were able to suggest topics

for discussion or training sessions. However, the nurses in the two special schools told us they were unable to attend; as there was no cover arrangement in order to release them from clinical duties at the schools.

- Physiotherapy teams held monthly training where they reviewed their continuing professional development and ensured mandatory training was up to date.

Multi-disciplinary working and coordinated care pathways

- There was an emphasis on multi-disciplinary working and the health visiting teams told us this worked well across the localities. Staff told us there was close links and joint working with the safeguarding team and the police to ensure information was shared appropriately. This included attendance at multi-disciplinary and child protection meetings.
- The health visiting teams worked closely with other allied healthcare professionals and referred children to the physiotherapy and SLT teams. The community children nurses (CCN's) had developed links with the inpatient teams and were kept informed of any patients discharges and planned care as appropriate. This included robust needs assessments to ensure the right support was available for children and young people prior to leaving hospital. They were also informed if a child in their care in the community was admitted to hospital.
- The CCN team had developed positive working relationship with the local hospice which provided 24 hour support to the team. The team received the trust's innovation for care 2015 award for joint working.
- Representatives from the CCN team visited the emergency department each day to check if children who had been seen in the department required support or treatment in the community.
- Physiotherapy teams worked with school staff and support workers to carry out physiotherapy sessions. We observed good interaction with school's support staff, school nurse and teaching staff at the schools we visited. This included collaborative work with the school team for moving and handling children. This allowed children to continue receiving physiotherapy throughout their school day rather than just during therapy sessions.
- Physiotherapy staff worked with school staff to provide teaching, for example the physiotherapy team had

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provided postural management training for 70 members of the school's staff. The physiotherapy team had also provided training for the health visitor team to reduce inappropriate referrals.

- The physiotherapy and occupational therapy teams carried out joint therapy visits to assess seating requirements for children and young people with complex needs. This reduced the amount of visits a child or young person would receive.
- Professionals from health visiting, school nursing and community therapies participated in child in need (CIN) meetings. These occurred every six weeks to discuss children with complex needs and their management.
- Professionals held a range of clinics at specialist schools; this included general paediatrician clinic, audiology, optometrist and dietician clinic. This meant children received appropriate support and did not have to miss lessons in order to attend hospital appointments.
- The health visiting team had monthly handover meetings with the midwifery team. Health visitors could carry out visits with the mental health team and midwives if needed. The team had started working with a recognised children's charity providing support and advice to parents and children either at drop in clinics or one to one support. .
- The school nurse team had worked with the Child and Adolescent Mental Health Service (CAMHS) to develop a strengths and difficulties questionnaire. This questionnaire was evidence based and recognised by the CAMHS team which aided the referral process. This was in pilot phase at the time of our inspection.
- School nursing teams told us they felt valued by social services and had good working relationships. Health visiting staff attended a hub meeting which was attended by locality counsellors, children and young people's charities, bereavement services, schools and women's refuge.

Referral, transfer, discharge and transition

- The child health information system allocated new born children who were resident in the area or registered with a GP, to the relevant health visiting team. The trust had protocols for health visitors and school nurses to follow when children and young people who were not brought

to hospital appointments and whose parents could not be contacted. These children were followed up in the community and staff liaised with other services as appropriate.

- There was a pathway for when children transferred from the health visiting service to the school nursing service and when children moved out of the area. This was a means of monitoring children in the community. This meant children in vulnerable groups were proactively followed up during transitions from one team to another.
- Staff told us transition from children's service to adult services for young people with complex needs would begin one year before they were due to transition. This involved paediatricians making referrals to adult services such as the learning disability service and adult social care and meant sufficient time was allowed to ensure a thorough handover from one service to another.

Access to information

- The variety of record keeping systems across the service meant staff may not have access to the full range of clinical details to plan for effective care and treatment.
- The school nursing and health visiting team had an information sharing agreement with the local safeguarding children board. This allowed staff to obtain information from other professionals in the trust to complete safeguarding reports.
- Staff across the children and young people's service were issued with laptops to allow them to connect with the trust's intranet in order to access policy and procedures. However, staff working in specialist schools could not access the trust's intranet.

Consent

- Staff demonstrated a good knowledge of Fraser guidance to ensure young people under the age of 16 years old, who declined to involve their parents or guardians in treatment, had sufficient maturity and understanding to enable them to give full consent. Gillick competence is a term used in medical law to decide whether a young person (16 years or younger) is able to consent to his or her own medical treatment without the need for parental permission or knowledge.

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Fraser guidance is used for young people under the age of 16 to decide whether they can receive contraceptive advice or treatment without parental knowledge or consent.

- School nurses had received training on Fraser guidance and Gillick competence and could give examples of when they had used this for example, when administering vaccinations or giving sexual health advice.
- However we found that staff did not always document if they assessed the young person's ability to consent. In an audit completed for the British Association for Sexual Health and HIV (BASHH) staff had not recorded that ability to consent was assessed for 18% of patients, this was higher than the regional (10.8%) and national (8.5%) average.
- The physiotherapy team gained verbal consent from parents to carry out therapy in specialist schools. This was obtained by telephone call prior to every therapy session and recorded in the children's notes
- The health visiting teams sought parents' consent to participate in the national healthy child programme. Parents we spoke with said they were happy for their children to be weighed and measured and they used this to monitor their child's progress.
- Children's community nurses told us there was no formal system for recording consent for children and young people. Records showed that there was no consent documented for any of the care or treatment given to children or young people in their own homes. The Department of Health, 'Seeking consent: working with children' states health professionals need consent to carry out all care and treatment whether working in hospital or in a child's home. The document states obtaining consent is a fundamental part of good practice and legal requirement.

Are services caring?

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

We rated caring as good because:

- All the patients and families we spoke with across the community children and young people's service gave positive feedback about staff and the care they had received.
- Staff treated children young people and their families with kindness and compassion.
- Staff respected the privacy and dignity of children and young people, particularly those with complex needs. For example staff booked appointments in the child or young person's home if they needed to undress the patient so they would be more comfortable.
- Staff put children, young people and their families at the centre of their work and developed individualised programmes of care for patients.
- Staff explained things to children and young people in a way they could understand, for example, using straightforward language.
- The health visiting team used maternal mood assessments to assess the emotional wellbeing of mothers after childbirth.
- The school nursing team had undertaken training in cognitive behaviour therapy and developed a questionnaire to assess the mental health of children and young people.

Compassionate care

- All the feedback we received from children, young people and their families was overwhelming positive. During our inspection we reviewed 11 feedback questionnaires from parents and three questionnaires from children and young people in relation to the physiotherapy service. All the questionnaires gave positive feedback with comments such as 'no need to change anything' and 'very happy'.
- Staff treated children, young people and their families with kind and compassionate care. We observed physiotherapy staff giving praise to children and young people with learning disabilities during therapy sessions to encourage them in their treatment. Patient's responded positively to this by smiling and laughing.
- Staff focused on patients as individuals. The physiotherapy team told us about a young person who had recently been paralysed from the neck down as a

result of meningitis. The physiotherapist had taken time to find out the patient's interests and had devised a circuit based physiotherapy session to help engage the patient in the session.

- The physiotherapy team told us they booked appointments to carry out assessments which required children or young people to be undressed at home. This was to ensure they were in familiar surroundings and had their parents with them.
- Staff in the sexual health clinic treated young people with dignity and respect. For example, we spoke to one young person who told us 'I suffer from anxiety but the staff were really kind'.

Understanding and involvement of patients and those close to them

- The children and young person's therapy team had collected feedback on Bobath therapy. Bobath therapy is an interdisciplinary approach to the management of children and young people with cerebral palsy. The data collected in June 2016 showed all seven parents who returned the questionnaire understood the therapy and felt they could ask questions both before and after the session.
- We observed a physiotherapist explaining what they were doing while hoisting a young person with physical and learning disabilities.
- The physiotherapist telephoned all parents of children at special school prior to seeing the child or young person. This gave the parents the opportunity to attend the appointment if they wished.
- We observed health visitors giving information to parents in clinic for example feeding advice.
- We observed a school nurse in a special school supporting a young person to manage their diabetes. The nurse supported and encourage the pupil to calculate their own insulin requirement and administer their own insulin injection.
- We observed staff giving health promotion advice to a young person in clinic regarding a coil enabling them to make informed treatment choices.
- Physiotherapy staff told us that parents and where possible children are engaged in developing goals and this is documented.

Are services caring?

Emotional support

- Health visitors gave parents time to express concerns or worries they had about their child's treatment. We observed health visitors discussing concerns such as breastfeeding, weaning and growth and development with parents.
- The sexual health service ran a clinic specifically for young people to access contraception, sexual health advice and testing for sexually transmitted diseases. We observed staff providing emotional support to young people, for example allowing them time to discuss concerns or feelings.
- During the parent craft sessions staff gave expectant mothers and their partners information and advice about postnatal depression. The class also included a meditation and relaxation session to teach expectant parents relaxation techniques.
- Following the death of a child, there was facility available at the hospice and a room could be arranged at very short notice to receive a child after death. Staff would decorate the room according to the child's/parent wishes and a cooling mat was provided. Staff told us this helped the family and siblings to be together and grieve as they were supported and remained with the child until the funeral.

Are services responsive to people's needs?

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

We rated responsive as good because;

- The children's therapy team saw all children within 18 weeks of referral.
- All staff we spoke with were aware of the service to meet the needs of the diverse population throughout the trust. There was a trust wide interpreter service available either face to face or via the telephone if needed for non-English speaking families
- There was evidence to show managers responded to informal complaints and made changes to practice. Information on how to make a complaint was readily available at clinics.
- Services were organised across a wide range of accessible hospital, school and community locations, include a mobile health bus, to promote improved access to healthcare, particularly for families living in poverty. The sexual and reproductive health service ran clinics specifically for young people including a one stop clinic for sexually transmitted infection testing, treatment and contraception. This was supported by school nurses who provided sexual health advice and support for young people in schools.

However,

- Informal complaints were dealt with locally in each individual team. However, these complaints were not logged as an incident and there was no evidence of shared learning from complaints.
- Information leaflets were only available in English and there was no information readily available for families whose first language was not English.

Planning and delivering services which meet people's needs

- Parents, children and young people had access to clinics which were held in easily accessible locations. These included children's centres and drop in clinics which and staff and people who used the service said met their needs.
- Service planning took account of the demographic needs of the local population. The level of poverty for children and young people under the age of 16 years was worse than the England average, although this was improving. Child health profiles showed 19.2% of

children and young people were living in poverty compared to the regional average of 13.7% and national average of 18.6%. Health visitors told us they worked proactively with families offering advice and support.

- The health visiting team ran parentcraft sessions where support and education was given to pregnant women and their partners. This included information on what to expect and choices during labour.
- The occupational therapy (OT) service for children with autism spectrum disorder was being developed aiming for initial assessments to be undertaken at school and at home. OT intervention deemed as clinically effective would be delivered at home. However there was only one clinical specialist OT to deliver the service. We were told that demands had been rising and were high which impacted on the referral to treatment time. There was no action plan to manage this.
- Children and young people's services have a statutory responsibility to participate in the development of Education Health & Care Plans (EHCPs) for children and young people as part of the special education needs (SEN) reforms. There was a work stream in place to transfer all current statement of special needs to EHCP by April 2018.
- There was no end of life facility for children at the hospice. Children and young people requiring end of life care received this in their own home with the support of the community nurses and hospice staff.

Equality and diversity

- The clinics and schools we visited were accessible to children and their families. This included those with restricted mobility or physical disability where designated parking facilities, entrance areas and toilets were available. There was sufficient equipment to ensure that people with disabilities and buildings complied with the Disability Discrimination Act 1995.
- All staff we spoke with were aware of the service to meet the needs of the diverse population throughout the trust. There was a trust wide interpreter service available either face to face or via the telephone if needed for non-English speaking families

Are services responsive to people's needs?

- Information leaflets were available in English only and the leaflets did not indicate that information could be accessed in other languages or formats.
- Staff told us that the trust were in the process of providing refuge to a number of unaccompanied asylum seeking children. However, we were told these children would likely be placed on the main land as the trust was not able to meet their needs.

Meeting the needs of people in vulnerable circumstances

- The staff we spoke with could articulate particular vulnerable groups within their own service. For example, in the sexual health service they knew to be vigilant for signs of sexual coercion in young people under the age of 16 years old.
- The health visiting and school nursing teams had recently started using a 'health bus' to run mobile clinics and health promotion events which was due to commence in November 2016. The mobile clinics were targeted in areas of deprivation and poor engagement to make the service more accessible. The school nursing team had also carried out a 'meet your school nurse event' at a local school using the health bus.
- The trust had recently employed a lead nurse for looked after children. There were working with health visiting and school nursing teams to develop assessments and intervention protocols for looked after children.

Access to the right care at the right time

- The children's speech and language therapy (SALT) team had a target of 12 weeks wait for a child to be seen at their first appointment. The trust provided data showing from November 2015 to October 2016 the average wait was five to 11 weeks. In this time period, the longest wait was 15 weeks which was in February 2016. The data provided by the trust showed a significant improvement in waiting times from 2014 to 2015. From November 2015 to October 2016, the 'did not attend' (DNA) rate for the SALT team was between three to 12%.
- The physiotherapy team provided data showing that from November 2015 to October 2016 the average waiting time was between three and six weeks. During this time, 12 patients waited over six weeks with the longest wait being 13 weeks. The trust told us this was due to paediatric musculo- skeletal caseload. The service lead told us they had implemented a range of

initiatives to reduce the waiting list including triaging all referrals and holding caseload review meetings. The physiotherapy team had an average DNA rate of 4.26% during this time period.

- Health visitor clinics were offered on a drop in or appointment basis. This meant parents could access information on topics such as healthy eating, safety precautions in the home and relaxation techniques at times which suited their needs when required.
- St George's school also held dental clinics and sexual health promotion for example teaching young people with learning disabilities safe sex practices. This meant children and young people could access healthcare without disruption to their education.
- The sexual and reproductive health service provided a clinic specifically for young people which offered a one stop clinic including screening for sexually transmitted infections and contraception. The clinic was staffed with two nurses who worked specifically with young people in clinic and the community.

Learning from complaints and concerns

- The manager of the health visiting and school nursing service had not received any formal complaints since being appointed to the post in April 2016. However, the manager had received informal complaints but these were not logged or recorded on the electronic incident or complaint management system.
- One example of an informal complaint was poor communication between a health visitor and parent of a child with autism. The manager shared this complaint with staff and arranged a training session for health visitors to become more aware of communication needs. However, as the complaint had not been logged it had not been used to improve care in a system wide way outside of the health visiting service.
- The physiotherapy manager told us they had received very few complaints and would try to resolve issues as they arise. Staff told us they would give information to patients about making a complaint if needed.
- We reviewed nine sets of meeting minutes including health visitor team meetings, health visitor locality meetings and physiotherapy team meeting minutes. None of these showed discussions about or learning from complaints had taken place.
- At the clinics we visited, there were information leaflets available to parents about how to raise a complaint. Health visiting and community children's nurses told us

Are services responsive to people's needs?

that they took a pro- active approach in resolving any concerns as they had close links with the family they supported. Information about the trust's patient advice and liaison service (PALS) was also provided as needed.

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.

We rated well-led as requires improvement because:

- Although staff spoke positively about the local leadership of the service, staff did not feel senior managers addressed serious issues in a timely manner. Many of the staff felt disconnected from the trust and felt acute services took a higher priority.
- The children's and young people's community team did not have a strategy to deliver or develop the service. Some teams had shown evidence of progression, however, there were no action plans in place to support development of services.
- Staff did not have a clear understanding of the trust's strategy, vision or values.
- Although the Clinical Business Unit (CBU) risk register included some of the risks from a department level there was no documented action to show how these had been addressed.
- Nurses working in special schools were at risk of isolation and did not have access to the trust's intranet, mandatory training or incident reporting systems. Staff used the governance processes within the school instead of escalating issues within the trust.
- The service did not have a clinical audit programme in place and participated in few national audits.
- The service did not have a robust system for collecting and monitoring patient feedback. Some services produced their own questionnaire but the trust did not provide any analysis of this feedback or action plans to show how it was responding to recommendations for improvement.
- We did not find evidence of significant improvement in areas highlighted as a concern in our 2014 inspection report.

However,

- Some services had shown innovation and were striving to improve. For example the community physiotherapy team had submitted a business case to develop a children and young people's respiratory outreach service to prevent hospital admissions.

- The school nursing and health visiting service had developed social media pages to engage with children, young people and their families.

Leadership of this service

- The leadership of the school nursing and health visiting team had been restructured just before the time of our inspection.
- As part of this restructure, three locality leads had been appointed to support the school nursing and health visiting lead. The school nursing service had seven senior band 6 school nurses and there was a vacancy for a school nursing lead.
- There was an overall lead for the school nursing and health visiting team who had been appointed in April 2016 with responsibility for the 0-19 years service. The overall lead reported to the head of nursing for the ambulance, urgent care and community clinical business unit who then reported to the trust board.
- Staff spoke positively about the overall service lead. Some staff told us they had previously felt 'stagnant' and were 'standing still' but the new manager had made a positive impact on the service.
- Staff including some service level managers did not feel senior leaders always listened or responded to their concerns. Staff told us they raised issues such as computer connectivity or lack of access to records through their manager to the executive team but these were never resolved. One manager told us they had tried to escalate issues which were consistently occurring and senior managers had stopped responding to their emails.
- Another manager told us that the clinical business unit manager was supportive but they did not feel they understood the level of risk relating to information technology and the duplication of records. They told us these issues were raised with the executive team but they did not receive feedback.

Service vision and strategy

Are services well-led?

- The trust had a vision to provide quality care to everyone, everytime which was displayed on the trust's website. Staff did not have a clear understanding of this vision or the values of the trust.
- There was no service vision or strategy in place for any of the children and young people's community services or for the service overall. This was highlighted in our 2014 inspection report.
- The Isle of Wight published a strategy 'My Life a Full Life' which included whole system integration with particular focus on health and social care, lifestyle risk factor management, sexual health, substance misuse, and children's public health nursing. Staff we spoke with were not aware of any trustwide strategy, for example, to reduce the level of obesity in children.
- The school nursing and health visiting team lead had recently submitted a business case to merge the school nursing and health visiting team budget. This meant they could potentially flex resources across the two services which they said they hoped would provide maximum efficiency for the service..
- Some staff told us they enjoyed working for an integrated trust; however, the majority of staff felt disconnected from the trust and were not familiar with the trust vision or values.

Governance, risk management and quality measurement

- The trust was divided into clinical business units (CBU's). Children and young people's community services were placed within the ambulance, urgent care and community CBU.
- CBU meetings were held on a weekly basis. Managers provided updates from their service through business service units and allowed an opportunity to escalate clinical or operational issues.
- Quality meeting were held monthly within the service to discuss topics such as staff appraisals, staffing issues and any quality issues. Managers told us a brief was sent to every manager from the CBU prior to the meeting and they were asked to provide a 10 minute update on quality issues within their service.
- . The school nursing and health visiting team had their own departmental risk register. This reflected the concerns of the team. For example, it included computer connectivity, duplication of records and reduction in staffing with increased child protection work. We reviewed the risk register for the CBU which

included the duplication of records as a risk. However, this risk had been on the risk register since July 2014 and had a review date of August 2016. There was no documented actions to state how this risk was being addressed..

- The service did not have a clinical audit programme in place and participated in a limited number of national audits. This meant the service could not monitor the quality of the service provided to children, young people and their families.
- The staff worked in their own localities and they told us this promoted continuity of care and had well developed links with other services.

Culture within this service

- Staff we spoke with were committed to providing positive experiences of care to children and their families/carers.
- Staff were supportive of each other and said they enjoyed their roles. Staff in some teams within the service felt disconnected from the trust and told us they were the 'poor relations' in the trust and given lower priority than acute services. Staff told us they felt there had been limited engagement from the executive team of the trust. Staff told us events had been organised by the executive team to meet staff but these had been cancelled or announced at short notice which did not give staff an opportunity to attend.
- Although staff told us they felt supported by their line managers, not all staff felt they would be supported if they raised concerns to senior management in the trust. One member of staff told us they would expect to be 'bullied' and 'hounded' if they raised concerns about the trust.

Public engagement

- The school nursing and health visiting team were developing a 0-19 liaison group focusing on parents, children and young people working with health visitors and school nurses to develop a social media platform.
- School nursing and health visiting teams communicated with the public through a range of social media. This included communications about health promotion topics such as young people's mental health and wellbeing, breastfeeding, and vaccinations. The service manager told us they were planning to develop a digital platform aimed at school-aged children.

Are services well-led?

- The South Wight school nursing and health visiting team ran an event at a local leisure centre during child safety week in June 2016. The purpose of this was to raise awareness of accident prevention and included activities such as taste testing to raise awareness of accidental poisoning.
- The service collected limited patient feedback. This was highlighted in our 2014 inspection report, however we did not find significant improvement. Service managers told us about a feedback survey called 'I want great care' which allowed patients and their families to provide feedback electronically. However, although we requested data from patient feedback survey, the trust did not provide this data.
- The physiotherapy service provided 11 'children's physio feedback questionnaire' responses which contained positive feedback about the service. Some of the respondents had highlighted that the building needed to be more child friendly. However, these responses were not collated and there was no action plan in place to address recommendations for improvements.

Staff engagement

- The school nursing and health visiting team sent out a team brief to update staff on changes to the service. The team also held a professional development meeting and were asked for suggestions about topics they would like to cover.
- The trust sent out a weekly newsletter to all staff called the 'Friday Flame bulletin'. This gave staff updates on changes in the trust and shared learning from incidents and complaints.
- Results from the 2016 NHS Staff survey the trust was in the best 20% of trusts for one question, and in the worst

20% of trusts for five questions (including overall engagement score). The trust was in the middle 60% for the remaining 26 questions and the response rate. One of the areas the trust scored worst on was 'recognition and value of staff by managers and the organisation.'

- The trust had an employee recognition scheme where staff could be nominated for outstanding achievements.

Innovation, improvement and sustainability

- We raised concern about a number of issues in our 2014 inspection report. These included the duplication of records, computer connectivity issues, lack of clinical audit programme and lack of strategy for the children and young people's community service. We found the service had not made any significant improvement to address these issues.
- The community physiotherapy team had developed a business plan for a paediatric community respiratory outreach physiotherapy service. If agreed, this would allow the physiotherapy team to support children or young people with complex needs at home if they had respiratory problems. For example, if a child or young person with complex needs had a chest infection the team could provide advice and support about positioning, breathing, suction and administer nebulisers.
- The sexual health service was in the process of implementing an initiative to reduce the numbers of termination of pregnancy. The service planned to develop a patient group direction (PGD) for health visitors to prescribe a progesterone only pill at new birth visits to prevent repeat early pregnancies and termination of pregnancies.

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

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

How the regulation was not being met:

- There was no documented evidence the children's community nursing team sought verbal or written consent from children, young people or their families to deliver care and treatment. Staff relied on assumed consent.
- Staff in the sexual health clinic did not always document they had assessed a young person's ability to consent to receiving treatment without a parent present in line with Fraser guidance.

Regulation 11 (1)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

- Compliance with some mandatory training modules was significantly low.
- Three medicine cupboards at Medina House School which were unlocked or the keys were stored in sight, next to the medicine cupboard.
- The medicine fridge storing vaccines at the school nurse base had a maximum temperature of 13 degrees recorded consistently. No action had been taken to resolve this or to inform the pharmacy team to ensure vaccines were safe and effective for use

Regulation 12 (1)(2)(c)(g)

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met:

- Key staff groups were not trained to safeguarding children level 3 as recommended in national guidance.
- The needs of looked after children (LAC) were not always addressed for example health assessments did not consider additional behavior or emotional needs and the 'did not attend' rate for LAC was significantly higher than the overall average.

Regulation 13(2)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

- The service participated in a limited number of national clinical audits and did not carry out any local audits.
- There were not robust systems to escalate and manage risks. Clinical business unit risk register did not reflect risks identified on the local departmental risk registers.
- There was a significantly low number of incidents reported and not all staff had a good understanding of when to report an incident.
- School nurses in specialist schools did not have access to the trust's incident reporting system and link in with the overall governance structure for this service.
- There was a mix of electronic and paper medical records system which led to duplication of records.
- Staff could not always import important information about patient's in a timely way due to the firewall or IT connectivity.

Regulation 17 (1)(2)(a)(b)(c)(f)(3)(a)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met

This section is primarily information for the provider

Requirement notices

- There were not sufficient numbers of school nurses to meet the requirements set out in the fundamental standards.
- Not all staff received appropriate or regular supervision

Regulation 18 (1)(2)(a)