Dorset Healthcare University NHS Foundation Trust

RDY

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)
RDYNM	Sentinel House, Nuffield Road, Poole	Head office	BH17 0RB
RDYGE	The Junction Sexual Health Clinic	Sexual health services	BH8 8DD
RDYX4	Blandford Community Hospital	Health visitors, Dental services	DT11 7DD
RDYFG	St Leonard's Community Hospital	School nurses	BH24 2RR
RDY62	Poole Community Health Clinic	Dental services	BH15 2NT
RDYFD	Wareham Hospital	School nurses	BH20 4QQ

This report describes our judgement of the quality of care provided within this core service by Dorset Healthcare University NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Dorset Healthcare University NHS Foundation Trust and these are brought together to inform our overall judgement of Dorset Healthcare University NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall this core service was rated as 'requires improvement'. We found that community health services for children, young people and families were 'good' for effective, caring and responsive and 'requires improvement' to be safe and well led.

Our key findings are:

- Staff did not demonstrate a consistent understanding or value of incident reporting. Some were not clear what should be reported and six staff from different professions said they were discouraged from using it. Incident analysis showed a high proportion of no or low harm incidents however which can indicate a safe reporting culture. There was evidence of high incident reporting rates in paediatric speech and language therapy, dentistry and sexual health services. Serious incidents were investigated to deliver improvements in practice.
- There were shortages of staff in school nursing, sexual health services and health visiting services. This was due to unfilled vacancies and, in some cases, high sickness levels.
- Medicines were not always checked or kept safe within sexual health services, which presented a risk to both patients and staff. There were clear procedures for the use of medicines for immunisation programmes however and for emergency medicines within dental services.
- There was low compliance with mandatory training in basic life support, adult safeguarding and fire safety. There were alert systems to prompt staff to attend updates training updates, but only a minority of teams had achieved over 85% compliance with all mandatory training.
- Patient records were comprehensive, clear and informative. They showed evidence staff addressed the needs of children and young people. Electronic records were used in all services, however with different systems used by services, there was variation in how safely they captured all the important information about children and young people's care and treatment.
- Safe infection control practices were seen in most situations.
- Business continuity plans were not robust with clear guidance to help staff know when to implement escalation procedures.
- There were safe systems and practices to safeguard children and young people from abuse.
- There were effective systems for supporting prompt referrals and working collaboratively to deliver the care required when a child or young person needed additional health or welfare support.
- Staff delivered programmes of assessment, care and treatment in line with standards and evidence based guidance. Patient outcomes were monitored based primarily on contact-measures but satisfaction surveys were also used to find out if patients and people using the services thought they had been effective.
- There had been some delays in reviewing the health of children in care, but this had been identified and action taken to clear the backlog of assessments.
- Children, young people and families received care, treatment and support from competent staff, qualified and trained for their roles. Access to training was good and new staff felt supported in their roles. Staff worked well with colleagues and with professionals in other disciplines to deliver a joined up service.
- Care pathways were based on recommended best practice and new guidance was incorporated into updated ways of delivering care. Arrangements were in place to support children moving between services and parents told us these were helpful and effective.
- Patients were asked for their consent before treatment was delivered.
- People spoke highly of the caring and kind staff, and the way they listened to their concerns. They were involved in decisions about their care, given time to consider options and put at ease if they were anxious.
- Staff coordinated care for the whole family and were committed to helping meet people's emotional, social and welfare needs as well as their health needs.
- Clinics and services were located in places where people could access them, and delivered at a range of times to accommodate people's different preferences. Community health services delivered a timely service to children, young people and families.

Summary of findings

- Locally, staff set up health and support groups required in their areas, for example to meet the needs of minority groups. Systems were in place to identify those who may be vulnerable and to provide targeted care.
- The school nursing service had reduced capacity to deliver public health improvement programmes, and some clinics and education sessions had been cancelled. This meant that some children and young people might not receive the support they needed at the right time.
- There had not been many complaints received by these services, but staff told us where complaints had resulted in changes to practice. Guidance on how to make complaints was not readily available however in the clinics we visited.
- Staff felt well supported in their teams and able to contribute to service development.
- There was a lack of clarity in the governance structures and staff were not sure that resources were adequately allocated to monitor and report on quality, safety and outcomes for people. The risk register was not consistent with staff concerns and there was not a strong culture for reporting and learning from all incidents and complaints. Services had carried out ad hoc audits, where they had identified a need, but there was no overall audit or service evaluation programme.
- Staff were committed to working together to provide a high quality of service. They were empowered to implement improvements in service delivery.

Dorset Healthcare University NHS Foundation Trust provides community health services for babies, children, young people and their families in Dorset, Bournemouth and Poole. These services include health visiting, school nursing, therapy services, services for looked-after children, sexual health services and services for children and young people with long term conditions, disabilities or complex needs. As part of this inspection we included the dental urgent care service and the intermediate minor oral surgery service.

We spoke with 108 staff for this inspection, reviewed 37 sets of care records and an extensive range of service documents. We received feedback forms from three people using the service and spoke with, or observed care and treatment for 53 parents, children, young people or carers.

Summary of findings

Background to the service

Dorset Healthcare University NHS Foundation Trust provides community health services for babies, children, young people and their families in their homes, community clinics, GP clinics or schools within Dorset, Bournemouth and Poole. These services include health visiting, school nursing, therapy services, services for looked-after children, sexual health services and services for children and young people with long term conditions, disabilities or complex needs. As part of this inspection we included the dental urgent care service and the intermediate minor oral surgery service. The staff providing these services are organised into 13 locality teams with some smaller services, such as sexual health services being managed within single locality directorates.

The health visiting and school nursing teams deliver the Healthy Child Programme (HCP) across Dorset, Poole and Bournemouth, supporting the health and wellbeing of children from birth to age 19. The HCP guidance from the Department of Health sets out the recommended framework to promote health and wellbeing. Children, parents or carers are offered a variety of health reviews, screening tests, support and information.

Most people in receipt of community services live in the south east corner of the trust, in the conurbations of Bournemouth and Poole, which have a combined population of about 450,000. Dorset, in contrast, is largely rural with many small villages, few large towns and no cities, with a population of about 200,000. The two largest towns in Dorset are Dorchester and Weymouth. Child Health Profiles for Dorset, Bournemouth and Poole show the level of child poverty and the rate of family homelessness are better that the England averages in all three areas. Infant and child mortality rates are similar to the England average, as are rates of childhood obesity. Nineteen percent of school children in Bournemouth are from a minority ethnic group, compared with 6.6% in Dorset and 10.1% in Poole. There are localised areas of deprivation within the trust boundaries, such as in parts of Weymouth, Boscombe and central Poole. The Public Health England Child Health Profile March 2014 predicts a 10% increase in 0-19 year olds in the area served by this trust, between 2012 and 2020, compared with a 6% increase nationally. This indicates a rising population of children and young people in the area.

Our inspection team

Our inspection team was led by:

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

Team Leader: Karen Bennet-Wilson, Head of Mental Health Inspections, Care Quality Commission

The team included CQC inspectors, managers and a variety of specialists including health visitors, school nurses, a sexual health nurse and a dentist.

Why we carried out this inspection

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?

Summary of findings

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 22, 23 and 24 June 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

For this core service with visited and spoke with staff at 17 clinics or health centres, two children's centres, three educational establishments and two hospitals. We spoke with staff in the three main localities regarding services for looked after children. We invited staff to attend different focus groups, for school nurses, health visitors, therapists and administration staff in Bournemouth, Blandford and Bridport. We spoke with service leads and clinical leads. We observed care in the intermediate minor oral surgery, contractive and sexual health clinics and in a variety of health visitor and therapy settings. We reviewed 37 sets of care records and an extensive range of service documents. These included performance or activity reports, service plans, minutes of meetings, care pathways and audit reports. We spoke with 108 staff across the service including health visitors, school nurses, administration assistants, community nursery nurses, dentists, dental nurses, therapists, nurses from the services for looked after children, leads for children's safeguarding, paediatricians and a volunteer. We also spoke with staff in management roles, locality managers and the director with responsibility for children and young people.

We received feedback forms from three people using the service and spoke with, or observed care and treatment for 53 parents, children, young people or carers.

What people who use the provider say

People we spoke with during the inspection and afterwards by telephone were complimentary about their experiences of care and treatment. They commented on the excellent listening skills of staff, and the way they supported the whole family with non-judgemental attitude, which built trust. Parents of children with complex needs used the following descriptions of staff, for example; "Problem solving", "Goes the extra mile", "Amazing, so helpful". We also heard comments such as; "Came just when I needed help", "Professional and knowledgeable", "Approachable" and "Friendly and happy to help – we were all treated excellently and my questions were answered fully with care and respect". People also told us that if they left messages on the phone for health visitors or sexual health staff, they phoned back promptly.

People told us they were given the information they needed, including leaflets about aftercare when this was needed. People liked receiving texts as reminders about appointments or clinics, for example for the breastfeeding clinic.

Parents attending health visitor clinics, including ones specifically for people with complex needs, said they liked the way health visitors invited other professionals, such as therapists or social workers to suggest strategies to help them support their children. They said the facilities where the clinics were held were good.

Good practice

Staff were dedicated and committed to providing a good service. Some examples of outstanding practice by individuals and services are listed below:

- The Dorset Working Women Project in Bournemouth, supported by the sexual health services, provided an outstanding level of care and support. The staff were dedicated and helped a very vulnerable group of women, going beyond their contracted duties. For example, they provided emotional support to women attending court cases regarding care for their children

Summary of findings

and they ensured the drop-ins sessions were enjoyable as well as practical. The staff also produced newsletters and coordinated charity work for the women.

- Enuresis service provided support to children and young people in a particularly caring and sensitive way. Feedback was used to develop the service and new equipment, that would improve outcomes and experiences for children, had been introduced.
- The breast feeding service in Bournemouth and Poole had received UNICEF Baby Friendly accreditation and people using the service were particularly complimentary about it. They liked the way health visitors contacted them and reminded them of clinics by text, and also that staff offered to visit at home if that was preferred. One person said "I wouldn't have had the energy to go out; it was great they came to my house".

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust MUST ensure

- Staffing levels are sufficient to deliver the health and wellbeing programmes for children, young people and families.
- Medicines are managed consistently and safely.
- Governance arrangements are robust, including management of the risk register.
- Business continuity plans provide clear guidance for staff.
- Mandatory training compliance is improved.
- An open and transparent culture where staff feedback and involvement is encouraged.

Action the provider COULD take to improve

The trust SHOULD ensure

- All staff are supported and encouraged to report incidents and complaints consistently to support continuous improvement in service quality.
- Mental Capacity Act 2005 training is delivered to all staff where this is needed.
- Service strategies are clear and communicated effectively.

Dorset Healthcare University NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Staff in services for children, young people and families did not demonstrate a consistent understanding or value of the incident reporting system. Some were not clear what should be reported and six staff from different professions said they were discouraged from using it. Incident analysis showed a high proportion of no or low harm incidents however which can indicate a safe reporting culture. There was evidence of high incident reporting rates in paediatric speech and language therapy, dentistry and sexual health services, which together accounted for 39% of incidents in one year. Serious incidents were investigated to deliver improvements in practice.

There were shortages of staff in some areas, including school nursing, sexual health services and health visiting. This was due to unfilled vacancies and, in some cases, high sickness levels.

Medicines were not always checked or kept safe within sexual health services, which presented a risk to both patients and staff. There were clear procedures for the use of medicines for immunisation programmes however and for emergency medicines within dental services.

There was low compliance with mandatory training in topics such as basic life support, adult safeguarding and fire safety. There were alert systems to prompt staff to attend updates training updates, but only a minority of teams had achieved over 85% compliance with all mandatory training.

Patient records were generally comprehensive, clear and informative. They showed evidence staff addressed the needs of children and young people. Electronic records were used in all services, however with different systems used by services, there was variation in how safely they captured all the important information about children and young people's care and treatment. The electronic records

Requires improvement

Are services safe?

for children in care, children's safeguarding teams and sexual health services for example were not linked to those in other children's services. This meant manual input of information was sometimes required to capture important information relating to child safety. Paper records were still used in some services, alongside electronic records, with a potential risk of omission or duplication of information

Safe infection control practices were seen in most situations. Staff cleaned equipment and washed their hands.

Business continuity plans were not robust with clear guidance to help staff know when to implement escalation procedures.

There were safe systems and practices to safeguard children and young people from abuse.

Where staff had concerns that a child or young person needed additional health or welfare support, there were effective systems for supporting prompt referrals and working collaboratively to deliver the care required.

Safety performance

- Between 1 January 2014 and 31 December 2014 there was one serious incident requiring further investigation which was attributable to the children, young people and families service. This incident concerned the removal of the wrong tooth by the intermediate minor oral surgery service. The service carried out a detailed investigation of the incident and implemented improved procedures to minimise the risk of a similar incident occurring. The event was discussed with staff for learning and the service had implemented audits to check that the revised procedures were implemented.
- Between 24 June 2014 and 23 June 2015 a total of 156 incidents were reported for the services covered in this report. Of these, 96% were classified as low or no harm. There were two moderate harm incidents and four near misses. This high proportion of incident reports of no or low harm is indicative of a safe culture for reporting incidents.

Incident reporting, learning and improvement

- The trust had an electronic incident-reporting system in place which staff said was straightforward to use. Staff working in paediatric speech and language therapy (SLT), dental services and sexual health services said they were encouraged to report incidents and gave examples of incident investigations including root cause analysis and lessons learnt. These services combined accounted for 39% of all incidents between 24 June 2014 and 23 June 2015. The SLT service accounted for 18% of reported incidents and these related to incidents resulting in no, low or minor harm. This indicated an effective reporting culture within this specific service.
- There was shared learning from an immunisation incident within school nursing, which resulted in the development and implementation of a revised consent form. Different teams of school nurses confirmed they used this new form.
- When asked about incident reporting health visitors and school nurses did not have a consistent understanding of what should be reported as an incident, with most stating they had never used the reporting system. They also gave mixed views of the value of reporting incidents with six staff commenting they no longer reported incidents as 'nothing happened as a result'. Staff in two clinics reported, for example, that aggressive behaviour from parents would not be logged as incidents. Most health visitors and school nurses reported a lack of feedback from incident reporting, which they found discouraging.
- All children's nursery nurses were required to complete training in recognising a sick child, as a result of a reported incident and an investigation highlighting this need.
- Central safety alerts were communicated to locality managers and cascaded to staff where appropriate. When asked however, some staff could not recall receiving any information about safety alerts that would have been relevant to their role.

Safeguarding

- Staff understood how to safeguard children and young people and could explain the trust's safeguarding arrangements. Staff had good access to the trust's children's safeguarding team for advice and were aware of named leads for safeguarding within their specific service groups for additional advice and support.
- Access to safeguarding training was reported as good by individual staff however trust data showed that three of the nine school nursing teams and three of the 13 health visiting staff teams achieved less than 85% compliance with Level 3 training in child protection.
- Arrangements for safeguarding supervisions for staff with child safeguarding cases varied slightly amongst

the different teams. Staff reported receiving group supervisions two, three, four or 12 times a year with the option of having one-to-one supervision on request. Trust guidance was for staff to receive a minimum of four supervisions annually. Newly qualified health visitor staff were supported to attend supervisions as often as required. Staff found the group supervisions useful learning opportunities especially when these included staff from different disciplines, who brought new scenarios for discussion.

- The trust had a dedicated, qualified safeguarding children's team, all trained to level 4 in safeguarding. Safeguarding advisors were allocated to support trust staff by locality.
- The trust safeguarding team worked well with the local children's safeguarding boards and trust policies were aligned with those of the local authority. The trust's safeguarding team received domestic violence reports for cases which involved children and information was shared to ensure those working with families were aware of the potential risks of harm. Children's safeguarding advisors also attended multi-agency risk assessment conferences for domestic violence when victims were pregnant or had children. Information from these conferences was shared with health visitors and school nurses so that those working with a family were aware of any risks of serious harm.
- Health visitors and school nurses were invited to safeguarding conferences and meetings. They attended initial conferences and then reviews where there was an agreed health risk. Health visitors and school nurses worked together to ensure that the most appropriate person attended the meetings.
- The trust had introduced an electronic records management tool for health visitors and school nurses in June 2014 and all children and young people with a child protection plan were identified on this system to aid information sharing. The sexual health team were not on the same system and this presented a safety risk to children and young people. Staff were not always aware if young people were on a child protection plan when they presented for sexual health services. Lists of at-risk children were shared with sexual health services to monitor their safety, however as this was manually maintained there was a risk of failing to keep this list up to date.
- The assessment framework used by the sexual health services included consideration of child sexual exploitation. Health visitors and school nurses were clear about their responsibilities to consider a child's safety, for example when they performed a pregnancy test. The safeguarding children lead attended meetings with the police and children's social care teams in relation to children at risk of sexual exploitation.
- Volunteers in children's services were checked through the criminal records bureau process to minimise the risk of exposing children and young people to people who could cause them harm.

Medicines

- Emergency drugs boxes used within sexual health services were kept in locked cupboards. The boxes were not tamper-proof, to minimise the risk of unauthorised access, in line with the Faculty of Reproductive Sexual Healthcare's (FRSH) services standards. There was no procedure for monitoring and recording expiry dates on emergency medicines, which the FRSH states should be completed monthly as a minimum.
- One box of emergency drugs in a sexual health clinic was out of date and removed at the time of the inspection. There was an alternative, in-date box, available to maintain patient safety. At this clinic, the algorithms relating to emergency procedures were not clearly displayed for easy reference for patient and staff safety.
- School nurses and health visitors did not carry medicines routinely, but school nurses managed medicines for immunisation programmes. Patient Group Directions (PGDs) were in place for medicines used in the vaccination programmes and for sexual health services. These had been reviewed and updated. The PGDs for immunisations had been approved by the medicines management committee and staff signed to show they had read them.
- Policies and procedures were in place for the safe management of medicines used for immunisations, and medicines storage temperatures were monitored and audited. The fridges used for storing medicines for immunisations were secured and alarmed.
- The school nurses had developed a training programme for schools, which included a DVD, to support them in managing pupils' own medicines safely.
- Equipment and medicines for medical emergencies was available at every dental site visited, and these complied with the Resuscitation Council (UK) and

British National Formulary guidelines. The emergency drugs were all in date and stored securely. Procedures were in place for routinely checking emergency medication.
- Emergency oxygen was stored safely in the sexual health clinics and was routinely checked.

Quality of records

- The trust had implemented the electronic records system for school nursing and health visiting services during 2014. This system was not used for records management by sexual health services, dentistry or services for children in care. These services maintained their own electronic systems however these could not be linked.
- School nurses and health visitors logged new referrals directly onto electronic records. Historical files were retained in paper format.
- Staff were generally positive about the functionality of the electronic records system, in that it prompted the completion of detailed records and supported effective information sharing between health visitor and school nursing staff. Administration staff scanned hard copy letters to GPs and minutes of meetings, for example from child protection conferences, into the system. This enabled users of the system to review people's medical history and interventions from health and social care agencies, where these had been added.
- Records showed good evidence staff addressed the needs of children and young people. They clearly demonstrated the chronology of significant events, consent forms and vaccination history. Where the new system was used, it also flagged up when children or young people had been assessed as requiring additional support from health services or were identified under the child protection framework.
- The records for children in care (where the local authority had responsibility for children's care and welfare) were completed effectively. They showed the child or young person's health plans, treatments and results.
- Dental records were clear and concise. They provided a detailed account of the treatment patients received, which included pain management medicines. Confidential information was protected and clinical records were kept secure.
- Records maintained by the sexual health services, on a different electronic system, were in line with professional guidance and clearly completed.
- The new records management system used by health visitors and school nurses contained a wide range of templates for assessment and care planning, with further templates planned, for example for speech and language therapists. Staff in sexual health services said their electronic records system was less well adapted to the needs of the service. As a stand-alone system, the records did not necessarily show when people had accessed other services, such as mental health services, or if there was a child protection plan in place, unless this was added manually. This meant that staff might not have the full medical and social history of patients, to provide the most appropriate care. A new template had recently been added to record children at risk of sexual exploitation.
- Records were stored securely. Access to electronic records was password protected and permissions were required for staff to access records relating to their professional discipline. Paper records were secured in locked cupboards or offices. However, there were some paper records in sexual health services that needed archiving.

Environment and equipment

- The trust had completed risk assessments of trust-owned premises, but staff told us that where clinics were held in church halls or GP practices, the trust environmental risk-assessments had not been completed. This might have put staff and patients at risk.
- Maintenance contracts were in place for all equipment used by dental services and there was a record of and plan for all routine maintenance. The trust had a contract with a specialist company to test for legionella bacteria in water systems, and a risk assessment had been completed in 2014. There were systems in place to minimise the risk from legionella, these included flushing of little used water outlets and the continuous disinfection of the water used during patients' treatments.
- Across the sites we visited we saw that clinic scales were routinely calibrated to maintain accuracy and audiology equipment was serviced.

Are services safe?

- Staff told us they completed a visual check of play equipment, such as plastic toys and mats at the start of clinics.

Cleanliness, infection control and hygiene

- Staff in the dental service were aware of infection prevention and control guidelines and good practices were observed. The service used offsite hospital central sterilising for the decontamination of instruments and equipment. Staff wore personal protective equipment (PPE) such as disposable gloves and aprons, and followed hand hygiene and 'bare below the elbow' guidance. There were adequate hand washing facilities and alcohol hand gel was available throughout the clinic area. Arrangements were in place for the handling, storage and disposal of clinical waste including sharp items.
- In health visitor clinics, staff used cleansing wipes, hand gels and clean paper sheets on scales when weighing babies. Staff cleaned their hands and cleaned equipment between patients. There were safe systems for disposing of waste such as nappies. Staff did not consistently adhere to the 'bare below the elbow' protocol or wear PPE to reduce the risk of cross contamination.
- At an audiology clinic, we observed that earpieces were cleaned between use, to minimise the risk of cross infection.
- Speech and language therapists and assistants were clear about the cleaning procedures they employed for toys and mats. All areas appeared visually clean.
- Staff were encouraged to submit forms, on a monthly basis, demonstrating that equipment had been cleaned. When asked, staff were not sure where the forms went to and did not receive feedback
- Infection control and prevention leads had been identified within locality teams, to provide local resources for guidance and support. This was still being implemented at the time of the inspection.
- We did not see any audits of hand hygiene, but these were part of the dental service's audit plan for 2015.

Mandatory training

- Completion of mandatory training was monitored and staff working in services for children, young people and families were required to keep up to date with a range of topics. These included safeguarding adults, safeguarding children, basic life support (BLS), fire safety, infection control, lone working, information governance and moving and handling.
- In April 2015, the trust changed the requirements for mandatory training for clinical staff in sexual health services, requiring them to complete annual the trust's Enhanced Life Support training. This had not been a requirement previously and staff had not yet completed this training. Patients receiving clinical treatments were at increased risk of harm.
- Staff were alerted when their training was due and they could sign up for refresher mandatory training on line. There had been a recent emphasis on staff completing information governance training, as shown in meeting minutes, and there was a high level of compliance in this topic.
- Training rates for 31 May 2015 showed staff were not up to date with their mandatory training. Only six out of 28 teams the within children and young people service (excluding dentistry) achieved compliance with BLS training, only 14 of teams were compliant with adult safeguarding and 15 with fire safety. Six staff teams showed they had not met the trust standard of 85% compliance with over five mandatory courses. Only four teams out of 28 teams achieved over 85% compliance with mandatory training, and these were all 100% compliant.
- Within dentistry, all staff had completed annual, three-yearly and one-off mandatory training. This was logged and the business manager monitored staff training against a checklist.
- Staff reported that access to training was good, and all those we spoke with were proud to have been up to date with their training.
- Staff were required to complete training for lone working, through 'breakaway', or conflict resolution courses. A high proportion of staff had completed this training, designed to promote personal safety for staff and patients.

Assessing and responding to patient risk

- The Healthy Child Programme (HCP) and National School Measurement Programme (NCMP) include assessment stages and tools to identify and respond to children and young people between 0 and 19 years of age who may be at risk of harm, disorder or ill health.

The HCP meant that risks relating to parental or child welfare or child development could be identified at routine checks carried out by midwives, health visitors, nursery nurses, school nurses and GPs.

- The service had implemented and embedded the HCP and NSMP and used these as the key opportunities for assessing and monitoring the welfare of children, young people and families and responding to identified risks. The trust had also documented the assessment framework for the assessment of health needs in families. This had the stated aim of providing an effective programme of health visiting contacts at the earliest opportunity, to aid improvements in people's health outcomes.
- The service had taken account of areas of deprivation, where families were at higher risk of experiencing social and health disadvantages, by allocating smaller caseloads to health visitors working in the more deprived areas. This meant staff were better able to provide appropriate support to children, young people and families at risk.
- The health visitors based at Providence Surgery in Boscombe were co-located with the 'Sunshine team', which provided care to vulnerable women, including victims of domestic violence, women who have problems with substance misuse and, teenagers and women who had been trafficked. This meant there was a good network established which identified families at risk. The staff met as a team twice a month to discuss risks and how best to respond.
- The service had arrangements to ensure that when assessments by health professionals showed people needed more targeted, responsive care, this support was coordinated. This included referral to professional support with toilet training, behaviour management or speech and language therapy. If children, young people or families were assessed as having more complex needs, requiring ongoing support from a range of local services the service was able to coordinate this care.
- For example, at a two-year check a child was identified by the nursery nurse to have delayed speech, and the child was referred to Speech and Language Therapy (SLT). When they did not attend appointments, wider service support was put in place. This was to encourage the family's involvement with health and social care services, as well as to help with the child's language development.
- All staff reported that concerns relating to specific children or young people were acted upon, and support was provided through team and multi-agency care and treatment. This approach was enabled by clear work plans for staff, the use of electronic patient record system to allocate 'tasks' to colleagues and established links with other health and social care professionals.
- Health visitors and community nursery nurses had received training on recognising deteriorating health in a child, with health visitors attending annual training from paediatricians.

Staffing levels and caseload

- School nursing staff in different parts of the trust said their service was understaffed and workloads were not equitable. The areas considered most at risk from understaffing were in Bournemouth, Poole and Bridport. The trust reported they had no system for assessing or determining the establishment staffing levels for the school nursing service.
- The trust was awaiting a needs analysis report from Public Health Dorset before adjusting working arrangements and allocating work equitably for school nurses, including reflecting on skill mix.
- Data for May 2015 showed school nursing teams in Christchurch, Purbeck, East Dorset and Mid Dorset had vacancy rates above 10%, with the former two teams having over 20% of posts vacant. In addition, the sickness rate in the North Dorset school nursing team averaged 14.5% for the 13 month period to 31 May 2015, against a trust's overall sickness rate of 4.7%. Staff reported there was rarely backfill for absent staff. Staff told us the use of the new electronic system for record keeping increased the time it took to document their work and they felt they were often 'fire-fighting'. As a consequence they reported providing a more limited range of services.
- School nurses said they had not delivered all aspects of the HCP effectively. They prioritised completing the immunisation programmes, which meant they had a reduced capacity to deliver health promotion and education within schools. In Dorset, the school nurses provided sexual health education in schools, whereas in Bournemouth and Poole this service was provided by the sexual health team. School nurses in Dorset said

they had cancelled some sex and relationship education in schools, as well as drop-in sessions, in order to complete the immunisation programme and carry out their safeguarding responsibilities.

- School nurses reported that the current staffing levels did not reflect the growing number of children and schools within the trust boundary, and the rise in emotional welfare needs amongst children. All schools were allocated a named school nurse. One part-time community nursery nurse said they were responsible for 11 schools yet others had less than five. They felt this was not a safe arrangement.
- The trust had successfully increased the numbers of health visitors with funding from the 'A call to Action: Health Visiting Implementation Plan 2011-2015'. Despite this, the service was showing a 9% vacancy level in May 2015, with the vacancy rate having increased following staff retirement and staff who had chosen to reduce their hours. The trust reported a delay in recruiting further staff to the service due to a range of factors, such as the time taken to recruit from abroad.
- The trust provided caseload data for health visitor teams for 2014 which showed caseloads of between 100 and 400 per health visitor. Smaller caseloads were allocated to health visitors working in areas of deprivation or in the more rural areas with dispersed populations. These were within the parameters recommended by the Community Practitioner and Health Visitor Association guidelines.
- The skill mix of health visitor teams varied across the trust. The recruitment of recently qualified staff meant some experienced staff supported colleagues by, for example, taking on a higher proportion of child protection cases. This was recognised as short term, and generally staff welcomed the mix of new staff.
- Within the children in care service there were staff shortages in Dorset, exacerbated by sickness levels. This had resulted in a backlog of review of health plans. School nursing staff had been assigned to provide support in this area to help mitigate the risks associated with the shortage of staff and the delay in completing review health plans. There was therefore a short term plan to improve outcomes for this group of people.
- Sexual health services also reported a shortage of staff, as a result of staff not replaced after they had left. This had an impact on staff, who had less flexibility in when they could take their annual leave.
- There were no issues identified for staffing levels in dental and speech and language therapy services.

Managing anticipated risks

- A business continuity plan had been agreed for school nurses in May 2015. This covered immediate actions to be taken should incidents occur such as a loss of utilities or a major incident including severe weather. Detailed guidance however had not been included to inform staff of the criteria needed to trigger the continuity response. For example, staff shortage was included as a potential trigger for the continuity plan, but the plan did not describe what constituted a critical drop in staffing level. Similarly, it was not clear what 'loss of IT' meant in terms of loss of business continuity.
- The Dorset Working Women's outreach team had implemented robust lone working procedures to manage anticipated risks to staff. They alerted the police where they were going and their expected arrival and departure times, carried lone-working electronic devices for direct communication and undertook visits in pairs. Staff who worked in lower risk situations used different approaches but also went out in pairs when appropriate and kept team members informed of their movements.
- Sexual health services managed the risk of failing to provide adequate student services, by providing additional clinics for students at peak, seasonal times.

Good

Are services effective?

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

Summary

Staff delivered programmes of assessment, care and treatment in line with standards and evidence based guidance. Patient outcomes were monitored based primarily on contact-measures but satisfaction surveys were also used to find out if patients and people using the services thought they had been effective.

There had been some delays in reviewing the health of children in care, but this had been identified and action taken to clear the backlog of assessments.

Children, young people and families received care, treatment and support from competent staff, qualified and trained for their roles. An analysis of training needs had been completed for school nurses and further training was planned. Access to training was good and new staff felt supported in their roles. Staff worked well with colleagues and with professionals in other disciplines to deliver a joined up service. Staff found ways to resolve barriers to collaborative, effective working. The most significant barrier was the use of different IT systems that were not linked to each other.

Care pathways were based on recommended best practice and new guidance was incorporated into updated ways of delivering care. Arrangements were in place to support children moving between services and parents told us these were helpful and effective.

Records showed people were asked for their consent before treatment was delivered, and this was also observed in practice.

Evidence based care and treatment

- The service delivered NHS England's Healthy Child Programme (HCP), which provided families with a programme of screening, immunisation and health and development reviews, supplemented with advice about health, wellbeing and parenting.
- The trust's school nursing service specification for 2015-16 enabled children and young people to make healthy lifestyle choices and improve their social and emotional wellbeing. To achieve this aim, school nurses were required to deliver health promotion and immunisation services, based on Department of Health guidance publications.
- The National School Measurement Programme (NCMP) measured the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels. This is a government initiative, supported by NHS England. The initiative provided an opportunity for staff to engage with children and families about healthy lifestyles. The service delivered this programme across all localities.
- Poole and Bournemouth breast feeding services had been accredited under the UNICEF Baby Friendly Initiative. This is an evidence based approach to improving the long term health outcomes for mothers and babies. The trust had not achieved this level of accreditation in Dorset, but health visitors in Dorset were all trained to deliver breast feeding support and further work was planned to develop consistent breast feeding services.
- The health visiting team had recently adopted the National Institute for Health and Care Excellence (NICE) guidance for assessing post-natal depression, using the Generalized Anxiety Disorder scale.
- Sexual health services followed guidance and service standards from the Faculty of the Royal College of Sexual and Reproductive Healthcare (FSRH) and other professional bodies. For example the clinical lead was developing a new set of procedures for fitting the contraceptive coil based on recent FSRH guidance.
- Asymptomatic screening programmes for the management of sexually transmitted infections were delivered in line with the National Chlamydia Screening Programme standards, and other guidance.
- The care pathways established for speech and language therapists were based on best practice. For example, the Autistic Spectrum Disorder pathway was linked to NICE guidance [CG128] and the service was delivered in line with the Royal College of Speech and Language Therapists clinical guidance 2005.

Good

Are services effective?

- The trust's policy for enuresis treatment had recently been reviewed and revised, based on NICE guidance. This policy had been developed through the school nursing Practice Development Group to agree a consistent level of service.
- The Practice Development Groups (PDG) for school nursing and for health visiting reviewed trust practices and standards of care and treatment, and allowed for local differences. For example, the PDG had assisted with the development of the antenatal course for mothers in the Boscombe area, the anaphylaxis policy and a new dietitian policy. Staff said they were advised of new policies and procedures through alerts on the internet.
- Within dentistry, dental radiography was provided in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This included maintaining records of equipment and it's servicing, having a named radiography supervisor and details of the access arrangements to qualified specialists in radiography. There were documented procedural rules to provide guidance to staff on the safe use of X rays.
- For children in care (CiC), the trust had developed clear pathways and specifications for health assessments. These were developed to reflect the multi-disciplinary approach for the completion of health assessments in a timely and effective way.
- The trust had not secured funding to provide the Family Nurse Partnership programme for first time mothers aged 19 and under.

Technology and telemedicine

- Staff working at clinics without access to trust computers had lap tops to record information outside offices, however staff said they were flexible in the way they used them. Most preferred not to use them during face to face appointments and clinics, and preferred to write up notes afterwards. Staff told us connectivity was a problem in some areas. Staff said these concerns had been raised with the trust and senior managers said a new server was going to be installed in Dorset in 2015.
- The electronic system used by health visitors and school nurses was not set up to text appointment reminders to patients, although this function was available within the software. Patients who received support from breast feeding teams and sexual health services reported receiving text messages to remind them of appointment or clinic times, or test results. They appreciated this as an effective and welcome means of communication.

Patient outcomes

- The trust monitored a range of performance measures for children and young people's services, to demonstrate achievement of evidence-based care and treatments.
- Performance measures for the HCP showed that babies and children received regular checks. In 2014-15, the service completed 84-98% of new birth visits within 14 days. The performance dropped towards the end of the year, with the reduction in performance attributed to different ways of calculating the results and also omissions in data capture. Ninety four percent of children received a 12-month review and 80% a two/two and a half year review. Health visitors asked all parents about breast feeding at the six-eight week check and results showed 48% had been totally or partially breast fed. This information enabled the service to monitor contacts with mothers and babies and assess their emotional welfare, growth and development.
- Results for the last quarter of 2014/15 showed that 99% of new born babies had received hearing tests, to assess whether they needed further intervention from health and social care services.
- Between 92% and 96% of children in reception and year 6 were seen by school nurses through the National School Measurement Programme (NSMP) in 2013/14. This was similar to the England rate of 94% and above the target rate of 90%. These checks enabled staff to identify children needing additional support. Qualitative outcome measures were not routinely collected to show the impact of these checks.
- Immunisation results for 2013/14 showed that 74% of children aged 13-18 had been immunised with booster doses for diphtheria, tetanus and polio, and 92% of girls had received the human papilloma virus immunisation. School nursing staff commented that immunisation rates were closely monitored and a focus of their work.
- Sexual health services monitored a variety of outcomes. They had performed a higher number of chlamydia screens than targeted by the national programme, carrying out over 900 against a target of 710 in 2014/15. The service provided medical terminations of

pregnancy, and saw 100% of women within two weeks of referral. The attendance at contraceptive health services was considerably higher than the targeted levels.

- The trust service report showed that the sexual health services provided in Bournemouth and Poole monitored the number of sexual health promotion sessions offered in schools and colleges. This data was not reported in Dorset as this aspect of the service was provided by school nurses.
- The annual report for children in care in Poole showed that in 2014/15 the service completed 90% of the review health assessments. The Poole service reported that 92% of children in care had completed their immunisations and 90% had accessed dental checks. In Dorset, 90% of children in care received a review health assessment in 2014/15 and 86% received their immunisations, against a target of 85%. The service reported that 77% of children in care had accessed dental checks, against a target of 80%. Not all children in care in Bournemouth received their review health assessments in the month due, and these were completed at a later date with their consent. The proportion of children in care completing their review health checks in Bournemouth dropped below the target of 90%, to 84%. The reasons for this had been analysed and the trust was taking steps to improve this performance, to support the needs of children and young people.
- The manager of the speech and language therapy (SLT) services said that further work was being done to develop patient outcomes measures, but they had access to entry and exit reports on individual children which could be used to assess outcomes.
- Where services had completed satisfaction surveys these were generally positive. Friends and family tests were carried out in 2015 in a range of services within health visiting and school nursing. More targeted surveys carried out by the enuresis service showed people would recommend the service to others, and that it had improved the quality of their lives.

Competent staff

- Staff reported good access to training and development. They said they were supported by their managers to attend specialist training to develop their skills.
- Within sexual health services, staff were trained to carry out their roles effectively. All staff that provided sexual health screening had completed training to support people with sexually transmitted infections (STIF level 1), which enabled them to follow best practice guidelines. All staff had received training from the police to identify and support children at risk from child sexual exploitation. The team leaders had completed a pharmacy course in non-medical prescribing and the service had secured funding to train two public health specialist nurses and two chlamydia nurses to attend contraceptive and sexual health training. The medical leads maintained records of competency and attended annual sexual health updates provided the Wessex GP Educational Trust.
- All dentists in the intermediate minor oral surgery service (IMOSS) were qualified with post graduate qualifications in oral surgery. The dental nurses also had post graduate qualifications, for example in radiography, and were supported to gain additional qualifications. Nurses and dentists were up to date with their continuing professional development and received regular appraisals, to ensure they had skills to provide effective care and treatment.
- A learning needs analysis had been completed recently for school nurses. This identified a range of training requirements which included training in emotional health. Children's nursery nurses required additional training to carry out continence assessments and other staff reported requiring training to support people with particular physical or mental disorders. Training in enuresis had recently been initiated and training in epilepsy was being rolled out.
- Health visitors reported good support for training and development. They had 26 practice educators and good links with the nearby universities in Bournemouth and Southampton. Newly qualified health visitors said they had external mentors for up to two years via the universities and were given reduced caseloads for the first year. They felt well supported with monthly supervisions, and clinical supervisions roughly every two months and quarterly group supervisions. One new health visitor was particularly positive about the support they had received from the trust and colleagues.
- The trust offered preceptorship programmes as well as access to NHS leadership programmes to promote staff development.

Good

Are services effective?

- All health visitors and children's nursery nurses had breast feeding training, based on the UNICEF Baby Friendly Initiative. In Dorset, the health visitors provided all the breast feeding guidance, whereas the services in Bournemouth and Poole were supported by breast feeding councillors.
- Both health visitors and school nurses commented on the effective Practice Development Groups. These offered staff clinical expertise and guidance, and supported staff with policy reviews and development.
- All staff we spoke with said they had annual appraisals. Trust data showed that the appraisal rate was above 95% in 22 out of 28 teams, with only 16 staff not having had an annual appraisal on 31 May 2015. Supervision varied, with most staff receiving group supervisions, with the option of requesting one to one meetings if required.

Multi-disciplinary working and coordinated care pathways

- There was good engagement with other health and social care providers to co-ordinate care for children, young people and families. Staff in all the services we reviewed described effective and committed multi-disciplinary working, with the only issues being related to staff capacity or IT. They commented on having a 'strong culture of group working'.
- Health visitors were generally based in GP practices and built good systems for sharing information about children and families. Health visitors in Boscombe reported good links with the GPs and local drug and alcohol rehabilitation services, as well as with children's services, mental health and housing services. They reported that these links helped them to identify people who were reluctant to engage with services and likely to be at increased risk.
- Health visitors had links with children centres in, for example, Boscombe, Weymouth and Poole and had regular meetings with the family support workers to monitor families, young people or children at risk. At Boscombe, the health visitors and family support workers arranged joint visits when appropriate. In Bridport, they held monthly meetings which included midwives, social workers and family support workers to identify and arrange referrals for people where necessary.
- Health visitors had links with the hospitals, to ensure they were advised of new births so they could support maternal wellbeing and any breast feeding concerns.
- School nursing teams had strong links with schools, and had completed work to raise the awareness of their services with GPs. They worked with schools in care planning and liaised with schools and health visitors when children had difficulties transitioning into primary school.
- Some school nurses teams had monthly meetings with the children and adolescent mental health services (CAMHS) team to review people's emotional and behavioural support needs. These links were better in Bournemouth and Poole than in Dorset. In Dorset however, school nurses had received guidance from CAMHS in how to bridge the gap between referral and the appointment to CAMHS.
- Health visitors and school nurses in Weymouth were part of a scheme to analyse reasons for why children failed to thrive, led by education services with involvement from health, local churches and the childrens' centre.
- Sexual health services worked with health professionals, counsellors and drug and alcohol teams in youth clubs and advice centres, and supported young people with a range of social and health needs. The Dorset Working Women's Project coordinated their services with a local charity, health services and social services to provide outreach workers to screen women for sexually transmitted diseases and to provide a community women's drop-in clinic.
- A specialist nurse for children in care reported good links with children's services and the clinical psychologist, as well as with services for children who had left care and adopted children. Health visitors and school nurses liaised with the team to provide parenting guidance for foster parents.
- Care pathways to deliver the HCP were in place, and were due to be reviewed in liaison with partners. These were integrated across different disciplines, and involved for example midwives, GPs, orthoptists and teachers. A group had been set up to review the HCP and associated pathways.
- A multi-disciplinary group had been set up to design a pathway and associated tools and guidance on milk intolerance and allergy. Once completed, dietitians trained health visitors and GPs. The new pathway enabled them to provide a faster response to people.

Good

Are services effective?

Referral, transfer, discharge and transition

- The trust had a policy and procedures for the transition of children from health visitor services to school nursing. The policy outlined the 'transfer or care' arrangements, including when it was necessary to have multi-agency meetings to discuss children with additional needs.
- School entry checks were completed effectively, with annual meetings between health visitors and school nurses to 'hand over' the cases of school aged children. These provided them with the opportunity to discuss vulnerable children. The handover was facilitated by the use of the electronic patient record system, which highlighted the cohort of children to transfer across, based on their birthday, and also flagged up any with particular needs. Health visitors retained access to files for children up to the age of five, or for longer if there was specific, agreed need and there was parental consent.
- When families moved into the area and registered with GPs, there were effective systems for GPs to liaise with health visitors and school nurses, to enable them to make contact within agreed timescales. This was face to face or by telephone depending on a risk assessment.
- The dental urgent care service provided dental treatment to patients out of hours. This service was provided to patients who may not have a dentist for their routine dental care or for patients who were unable to get an urgent appointment with their own dentist. The out-of-hours service sent copies of treatment histories and outcomes to the patient's usual dentist to assist with follow up.
- The IMOSS provided oral surgery for patients referred by their dentist. This was for treatment they were not able to provide and as an alternative to referral to secondary care. Treatment outcomes and discharge details for any follow up were sent to the referring dentist.
- There were protocols for contacting children, young people and families if they failed to attend GP or clinic appointments. The government guidance 'working together to safeguard children' highlights the importance of information sharing to protect children from harm.
- Children and young people were referred for paediatric speech and language therapy (SLT) through a variety of routes, including from paediatricians, health visitors, school nurses and from parents or carers. There were clear referral criteria and all children were entitled to the 'targeted' level of service, which involved assessment, goal planning, advice and directing them to other services. Referral was triaged and involved discussions with health visitors and therapists, so that more urgent cases could be prioritised. Parents told us this was a good service and trust monitoring showed the 18 week referral rates were met.
- SLT referred children to more specialist care, for specific clinical care and interventions, for example for Autistic Spectrum Disorder, in line with their care pathways.

Access to information

- The services used a range of electronic records systems, with school nursing, SLT and health visiting services using one system and sexual health services, dentistry and services for children in care all having their own, different systems. These were mostly electronic however they were not able to communicate with each other to support information sharing. Staff recognised the risks associated with this and in some cases, produced paper records to share with other stakeholders. For example services for children in care prepared duplicate paper files to ensure information could be shared effectively.
- Although the electronic records system used by health visitors was also used by some GP practices, permissions were not always in place for share information between their systems and the trust's network. This meant that staff had to continue to rely on verbal updates or log onto different systems to review information about children and young people on their caseload.
- Where necessary, staff scanned in reports, letters and minutes from meetings to complete the chronology of people's care. Records we viewed showed a clear history of care.
- Health visitors and school nurses were generally positive about the functionality of their records management system, as it supported information sharing between different professionals, including speech and language therapists.
- School nurses and health visitors worked with historical paper records, stored locally for easy reference, as well as electronic records. Staff reported that paper records were readily accessible when they needed to refer to them.
- The electronic records system used within sexual health services did not support effective information sharing

with other services for children, young people and adults. Staff in sexual health services also commented their records system was not effective in recording and highlighting a person's status in relation to blood borne viruses.

Consent

- Records showed evidence that consent was gained for care and treatment, and for information sharing with other health and social partners where appropriate.
- Observations of practice within dental services, speech and language therapy, sexual health services and health visitor clinics showed staff asked for people's consent before offering any care interventions.
- We observed a consultation where staff clearly involved a patient in decision making about a procedure, and then accepted the patient's preference to decline treatment.
- Consent was clearly documented in dental records. The service used NHS consent forms which prompted a professional discussion between the dentist and the patient about a procedure, before it was performed.
- There were protocols for gaining parental consent for school entry health checks. Procedures had been modified for gaining immunisation consent, as a result of a near miss incident, where consent had not been adequately checked.
- Staff who worked with young people described how they applied Fraser guidelines when assessing a young person's competency to consent. These guidelines provide the legal framework for deciding whether a child or young person is mature enough to make decisions without parental consent.
- Written consent was obtained for patients receiving medical terminations of pregnancy.
- There was a variable understanding of the Mental Capacity Act 2005 and how it related to people aged 16 and over who may not have the capacity to consent to care or treatment. Most people were aware of the broad principles of the Act, but not the detail. Training on this legislation was being rolled out and was only mandatory for team leaders at the time of the inspection.

Good

Are services caring?

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

Summary

People we met in clinics and hospitals spoke highly of the caring and kind staff, and the way they listened to their concerns. Staff ensured people experienced compassionate care, and care that promoted their dignity and human rights.

People were involved in decisions about their care, or the care for their family, given time to consider options and put at ease if they were anxious.

Staff coordinated care for the whole family and were committed to helping meet people's emotional, social and welfare needs as well as their health needs.

Compassionate care

- In all the areas visited, staff provided treatment and care in a kind and compassionate way, and treated people with respect. People we spoke with were complimentary about the attitude of staff, and the way they spoke with them or their child.
- There were some situations where privacy could have been improved. For example, in one drop-in clinic we found the health visitors had set up their weigh stations close together, which made it difficult for people to talk confidentially with the health visitor. People attending the sexual health clinic in Bridport could be overheard in the reception room. However, in most places we visited, there were rooms where people could meet with health visitors privately. When health visitors felt people might prefer to talk about a confidential issue, we observed they discreetly invited people to talk in a private room.
- Observations of dental care showed people were treated in courteous way and with kindness. Dentists ensured people were put at ease before and during any treatment.

Understanding and involvement of patients and those close to them

- We observed interactions between staff and patients or children in a range of situations, including at children's health clinics, in contraception clinics and during dental appointments. Care and support was provided in a non-judgemental way and we observed staff talk through people's options in a clear and open way.
- Staff took time to explain treatment or care plans, and involved children and young people in any decisions that were needed and used appropriate language and approaches.
- The trust had an informative websites which explained their services for children, young people and adults. The websites included information about clinics, how to obtain a referral and different care pathways.
- There was a dedicated website for sexual health services in Poole and Bournemouth, called f-risky, with clear information and guidance, designed to be accessible for people wanting information about sexual health services.
- Children in care were involved in agreeing their care plans, which included health plans, and these were written in a style appropriate to their age.
- Information and guidance materials were available to people in clinics and given to people at appointments. For example, parents attending paediatric SLT appointments were given picture cards to use with the children at home, to assist children in achieving their development goals. Hand-outs were provided to parents at clinics, and we were shown the leaflets given to new parents moving into the area. These explained the services and included contact details.

Emotional support

- In all cases we observed, staff showed a commitment to providing emotional support in addition to healthcare or treatment. For example, dental staff recognised the importance of reducing patient's anxiety levels and helped people manage their fears or expectations. Health visitors provided a range of examples of how they supported the wellbeing of the family, as well as the individual child.
- The Dorset Working Women's Project provided a particularly caring service, by supporting women in a variety of emotional and practical ways. People using

the service were very appreciative of the service because it offered guidance for their safety, sexual health tests and charitable support for them and their children.

- Parents of children with complex conditions said the health visitors were helpful and considered the needs of the entire family as well the individual child. They also welcomed the support given which helped the child progress to school.
- People told us they were particularly relieved to have been given a number to phone by their health visitor, to use if they needed any kind of advice. Those that had used it said their calls had been responded to quickly and the staff had given clear advice that had allayed their worries. Sometimes this had meant they avoided a trip to hospital or to their GP.
- Results of service questionnaires to children in care and their carers showed people found the nurses to be caring and attentive. They included comments such as, the nurse 'interacts well' and 'is available to both carers and the young person to offer advice and guidance'.

Good

Are services responsive to people's needs?

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

Summary

Services had been restructured in 2014 to support a joined up approach between different professions to deliver services for people. There were still some inconsistencies in the services provided as a result of these changes, but they were being identified and resolved where necessary. Clinics and services were located in places where people could access them, and delivered at a range of times to accommodate people's different preferences.

Locally, staff implemented the health and support groups required in their areas, for example to meet the needs of minority ethnic groups, travellers and people at higher risk of poor health outcomes. Systems were in place to identify those who may be vulnerable and to provide targeted care.

The school nursing service had reduced capacity to deliver public health improvement programmes, and some clinics and education sessions had been cancelled. This meant that some children and young people might not receive the support they needed at the right time.

Community health services delivered a timely service to children, young people and families. With a few exceptions, services met their performance targets and where there were any, waiting lists were managed effectively and response to patient need.

There had not been many complaints received by these services, but staff told us where complaints had resulted in changes to practice. Guidance on how to make complaints was not readily available however in the clinics we visited.

Planning and delivering services which meet people's needs

- The trust's strategy document for 2014-19 reflected on the increasing demand for services for children and young people, which had resulted from a steady increase in population of 0-19 year olds and an estimated growth in the numbers of children living in vulnerable circumstances. The strategic direction for community services has been to transform services to deliver personalised, integrated care. To this end, community services, including those for children, young people and families, were reorganised in October 2014 into the current locality structure, to promote integration of physical and mental health services.
- The service leads had liaised with the extensive range of commissioners involved in services for children, young people and families. Information about the demographics had been used to inform recent and current tendering processes.
- There were some inconsistencies in service provision, often as a result of historical factors. For example, in Wareham, where there were no breast feeding counsellors, staff said they encouraged mothers to access services in Poole. Plans were in place to address this however, by training nursery nurses and creating breastfeeding champions.
- In Bournemouth and Poole, children could be referred to the 'Two to talk' programme, run by community nursery nurses in children's centres, to help parents learn how to support their child's speech and language development between the ages of two and three. There was a referral pathway, with clear criteria. This service was not available in other areas but there were plans to extend this throughout Dorset.
- Current services were aligned to national programmes, such as the HCP and NCMP, with set key performance indicators to monitor progress. At a local level these had been adapted to meet local need.
- Clinics to support the HCP were set up in suitable and accessible locations to meet people's needs. People attending the clinics said they were convenient but also knew they could attend alternative clinics if they preferred, in different areas. Often clinics were held in children's centres, with a range of additional facilities available for children and families. These included play areas, café facilities and rooms for confidential discussions.
- Staff gave examples of establishing clinics to meet a specific local need. For example, in Boscombe health visitors had set up a drop-in clinic for 'fussy eaters' as well as a more targeted service, accessed by referral, to support healthy eating in toddlers.
- To deliver the HCP, the service provided a range of drop in clinics for mothers with babies and young children, as

well as more targeted support groups. Parenting groups were available on referral. These were delivered by nurses trained to provide a programme of emotional and behavioural support. Drop in clinics were also available in primary and secondary schools, for teachers, parents and children to obtain advice from school nurses and sexual health nurses.
- Sexual health services were delivered from a range of venues, which offered people choice. For example, in Dorset, where the rural spread of population mean it might be difficult for young people to access clinics, more drop-in sessions were held in secondary schools.

Equality and diversity

- Locally, services had been developed to reflect the needs of the population. For example, in Dorset, health visitors had addressed the specific needs of the travelling community, and had focused on delivering a comprehensive immunisation programme for them.
- There were also areas with a high proportion of people from Eastern Europe. In Boscombe, health visitors outlined how they had assisted with language translation and in Dorset, a buddy system was planned to encourage this minority group to engage with services provided in children centres.
- In each area, staff reported good access to translation services, and were able to request female translators specifically. There was also a range of written information in different languages. The sexual health services were complimentary about the quality of the translators they used.
- Sexual health services provided a wide range of guidance materials, and these included some easy read leaflets. These were also available on their internet pages.
- The service had provided some men-only clinics, as well as clinics specifically for young people.

Meeting the needs of people in vulnerable circumstances

- Staff demonstrated a good understanding of the needs of the local population where they worked.
- In areas with high levels of deprivation, health visitors investigated reasons for non-attendance at GP or clinic appointments, as often these were indicative of wider health or social concerns. They asked why people had not attended and found people wanted additional services to be available. As a result, the service set up an ante-natal course with housing and benefit officers on hand to provide advice. Boscombe health visitors also attended the rehabilitation services for mothers who had received support to remain free from drugs and alcohol. The health visitors used the meetings to provide health advice. This approach had enabled them to reach and support people in vulnerable circumstances.
- Support groups were provided in Bridport children's centre for young parents, and for under 5's with additional needs, supported by physiotherapy and other services.
- The Dorset Working Women Project provided a range of services to support people's emotional wellbeing as well as providing sexual health services. These included a weekly drop-in session where women could receive support from trained project workers.
- Drop-in clinics were also provided for families with children with special needs. Therapists provided support at these clinics and parents also found them useful for social support.
- Sexual health services had also identified areas of localised high teenage pregnancy rates. In response, they had provided two lunch time and one afternoon session a week at the local school to deliver contraceptive and sexual health services.
- Children in care were referred to a range of services based on their specific needs, from enuresis to smoking cessation services and a community paediatrician. The service's three annual reports from Bournemouth, Poole and Dorset showed there had been delays in the completion of health assessments and therefore the identification of specific support and treatment options for children and young people. Actions were planned to improve outcomes for children in care.

Access to the right care at the right time

- Overall, children, young people and families received timely community health services. With a few exceptions, services met their performance targets and where there were any, waiting lists were managed effectively.
- In Bournemouth and Poole 84% of new mothers were contacted by the breast feeding team, within 48 hours of giving birth, to ask if they needed support with breast feeding. This enabled support to be given promptly and when needed.

Good

Are services responsive to people's needs?

- Health visitor new birth visits and development reviews were completed within the target timeframes. In 2014-15, the service completed 84-98% of new birth visits within 14 days.
- Clinics were managed effectively. Administrators helped to organise the sessions so people were seen in order of arrival, or prioritised if necessary. They were held at a range of times during the week, with some ante-natal clinics arranged in evenings to help working parents. Timetables were available for people to refer to.
- Health visitor clinics for people with learning disabilities needs ran through school holidays, which people said they appreciated.
- Health visitors had set up their baby clinics to coincide with GP immunisation clinics in Wareham, for improved convenience for families.
- People told us that clinics or drop-in sessions were rarely cancelled, but staff reported this did sometimes occur, due to staff absences.
- Within sexual health services, there were walk-in clinics six days a week, at times that were convenient to people. There was timely access for fitting of contraceptive devices and emergency contraception services were prioritised appropriately. Waiting times were monitored and administrative staff managed clinic lists sensitively to ensure people were seen promptly.
- Attendance rates at clinics were monitored, and 'Did Not Attend' (DNA) rates were high in some services. Monthly DNA rates for paediatric SLT appointment were between 1% and 14% over the past year, and in sexual health services they were 9-14%. The reasons for these rates were not clear.
- People referred to enuresis or SLT services were seen within the agreed timeframes. There were options to prioritise cases where there was an urgent need. Performance measures showed the service achieved the 18-week referral to treatment target, with the service offering group therapy to children and young people within eight weeks of referral.
- The SLT service provided pre-school support for children identified with speech and language development difficulties, with 'Small Talk' session set up at nurseries in Bournemouth and Dorset, two mornings a week, for 16 children.
- There had been a delay in the completion of initial health assessments and reviews for children in care. Although completion of the initial assessment is the responsibility of doctors at Poole Hospital this had been identified, and actions were being implemented to reduce the backlog and improve the timeliness of reviews.
- The out of hours dental services was available Thursday evenings, all day Saturday, Sunday mornings and bank holidays, therefore at times when people were least likely to have access to their own dental practice.

Learning from complaints and concerns

- Most staff reported that they received very few complaints, if any, and they always aimed to resolve people's concerns at the time of the complaint. They said they would not report concerns as complaints. This meant there was not a consistent approach to logging, investigating and learning from complaints.
- Guidance on how to make a complaint was not on display in the areas we visited. This meant people were not prompted to formally raise their concerns with the trust. The people we spoke with however all said they had no reason to make a complaint.
- There had been 25 complaints relating to services for children, young people and families in 2014/2015. Of these 12 related to paediatric SLT and sexual health services. Most related to the attitude of staff, or concerns with referral or treatment. The SLT service had improved the information made available to people about its service in order to clarify the referral procedures and explain the potential waiting times for appointments. The information package also included advice on actions that could be taken in the meantime.
- There had been shared learning from a complaint made to the sexual health services, which had resulted in a new procedure for following up on patients after a medical termination of pregnancy.

Requires improvement

Are services well-led?

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

Summary

Staff felt well supported in their teams and able to contribute to service development. They recognised the benefits of working in geographically based, mixed teams, for improved collaboration with other professionals but were not consistently aware of the trust's vision and direction. There had been many recent changes in the trust's structure and there was a mixed view of the visibility of senior managers and the executive team.

Governance arrangements were not robust. There was a lack of clarity in the governance structures and staff were not sure that resources were adequately allocated to monitor and report on quality, safety and outcomes for people. The risk register was not consistent with staff concerns and there was not a strong culture for reporting and learning from all incidents and complaints. Services had carried out ad hoc audits, where they had identified a need, but there was no overall audit or service evaluation programme.

There had been a variety of changes within this trust over the past three years and there was not yet a consistent 'trust' culture or management style, but staff were committed to working together to provide a high quality of service. They were empowered to implement improvements in service delivery.

Service vision and strategy

- The trust's vision was 'to lead and inspire through excellence, compassion and expertise in all we do'. 'Better every day' was an updated version of the vision, used on the most recent trust literature. This strap line was not referred to by staff and did not appear to be well known.
- Staff were aware of the trust's vision and values in general context, however they were not sure how this was reflected in a service-level strategy. The staff recognised the benefits of the geographically-based locality teams, with a mix of professionals which included health visitors, school nurses, district nurses and children and adolescent mental health services. This organisational structure was still being embedded at the time of the inspection, to promote collaborative working in mixed, integrated teams.
- School nurses were waiting for the outcome of the commissioners' school nursing service review. They were not able to deliver the health care promotion components of the HCP effectively, due to capacity constraints and other priorities, and were concerned this had not been identified and addressed.
- Staff and services were affected by tendering processes. The dental service had recently lost a tender to provide paediatric community services and sexual health services were preparing to retender at the time of the inspection. Investment in integrating IT systems for sexual health services was on hold pending the result of this tender.
- Health visitors welcomed the increased staffing levels from the 'A Call to Action' plan, and said the structure of the HCP helped them deliver a consistent, high standard of care.

Governance, risk management and quality measurement

- Staff understood their new operational locality management structures but were not clear how governance arrangements supported the new ways of working.
- Within the three main localities, community services were divided into 13 smaller localities. The management of specialist services, such as speech and language therapy, sexual health and services for children in care, were allocated to specific locality teams. Organisational charts were available for staff to refer to, but some staff commented that the new structure had not been fully explained.
- The 13 localities were made up of teams of professionals from different disciplines with team leaders. Not every discipline was represented in each team, for example there were health visitors but no school nurses in the Weymouth and Portland locality team.

Requires improvement

Are services well-led?

- Regular monthly or bi-monthly locality meetings for team managers and monthly team meetings had recently been established under this new structure. The locality meeting standard agendas included reports on performance, quality, complaints, workforce, training and appraisals.
- Specialist services held their own meetings. For example, speech and language therapists were organised into four clusters and held regular service meetings, reporting on performance, workforce, NICE updates and training. Actions were agreed at meetings and recorded.
- Staff reported that mechanisms for sharing information across groups of staff were inconsistent. For example, school nurses said they felt teams in Bournemouth were advised of training and events before teams in Dorset. Staff also commented that opportunities for sharing good practice and ideas between the different teams operating in high deprivation areas were missed, for example between Boscombe and Weymouth.
- The risks associated with different IT systems were not fully assessed or mitigated. Staff gave examples where people's care was delayed because systems were not integrated. The health visiting, school nursing and SLT teams used one system for creating and sharing electronic records, which was also used by some GP practices. Services for children in care, dentistry, safeguarding, community and adolescent mental health services (CAMHS), acute services and sexual health services each used a different electronic records system. Where this was a known risk, services had developed 'work arounds' to facilitate effective information sharing. For example, when children had a number of attendances to the emergency departments in Poole or Bournemouth hospitals, the hospitals faxed concerns to the school nursing teams, and the information was scanned into the electronic system and thereafter allocated to the appropriate member of staff.
- Some staff were concerned about losing the benefits of regular meetings with colleagues of the same discipline, to discuss quality and performance issues. This had been raised for further discussion at locality meetings, and plans were being developed to facilitate this. The practice development groups went some way to addressing this need.
- In some service disciplines there were regular team meetings. We observed a dental team meeting, and these were held frequently. Staff were involved in improvements and asked for ideas.
- Staff and team managers were not always aware of the service risks or what was on the risk register. Staff told us that risks associated with workforce changes were not fully anticipated. For example, advertisements to appoint to posts when people retired or left the service were not generated in a timely way. Some school nursing teams had experienced long term vacancies, of up to two years. The staff were not confident that the risks associated with staff vacancies were fully understood or managed effectively.
- Failure to recruit school nurses was included on the trust's risk register. This was classified as a low (level 2) risk. The risk register stated the action to control this risk was to review the current team structures and to arrange training for new specialist community public health nurses (SCPHN) from September 2015. No further actions were listed to mitigate the risks associated with the failure to recruit and the low risk rating meant the risk would be reviewed infrequently. This suggested there was not a clear plan for minimising risks associated with staff vacancies.
- Not all staff were confident in the use of the IT system for reporting incidents, complaints, appraisals and supervisions. Staff had also identified a data quality issue in reports on training and appraisal data.
- Team leaders reported difficulty in finding protected time for governance and management responsibilities.
- Staff were aware of serious incidents or near misses but were not able to describe any analysis of trends.
- The services did not have a consistent, systematic audit programme to monitor the quality of care and identify areas for improvement. For example, regular, monthly audits of records were not reported within the health visiting and school nursing services, to highlight where improvements could be made.
- Different individual services within the children, young people and families' service had carried out audits relevant to their particular practice. For example, in dentistry, there had been audits of the surgical checklist, and findings had led to actions for further improvement. The service had also agreed infection

control audits with the trust's infection control lead, and asked patients if they had suggestions for improvements. They had also carried out clinical audits, for example of radiography.

- The service for children in care in Poole for example had audited 20 records in January 2015 and actions had been carried forward with a follow-up audit planned. Ofsted inspected services for children in care in in Bournemouth in April 2014 and had identified some improvements were required in the initial health assessments. The service took action in response to this finding and a subsequent audit showed good quality records.
- In August 2014, a group of young inspectors inspected services for children in care and care leavers. Their feedback was mostly positive, but they also pointed out that children in care had no access to a male nurse in Poole. This feedback was not addressed in the service's annual action plan.
- Service level governance arrangements were more robust in the dentistry and sexual health services.

Leadership of this service

- Staff knew their locality manager and director, and some staff were aware of members of the trust executive leadership team.
- Staff were almost entirely positive about the skills, knowledge and experience of their immediate managers and felt they were well supported. However, staff felt there was a disconnect between the trust board and staff providing community services for children, young people and families.
- On some occasions staff felt their manager did not understand their role or particular challenges, if their experience was in a different area, but mostly people felt they worked within a cooperative, committed team.
- Due to the particular construction of the locality structure for school nurses, one school nurse team leader had a lead role for three teams of staff in Christchurch, Purbeck and East Dorset and consequently reported into the three different localities. This created complications in reporting and sharing of information. Staff also commented this impacted on the leader's capacity to manage effectively.
- There were some managers who covered more than one area, or carried out a role previously performed by two people. They reported that they needed additional support.
- Staff thought that the leadership teams did not anticipate risks to the service and escalate them effectively. For example, in the sexual health services, staff told us about a pending closure of premises. Health visitors said that forthcoming vacancies were not advertised promptly. These types of concerns caused staff to worry about the leadership and direction of services.
- Although senior managers and team leaders understood the challenges of the services, they did not always communicate whether these challenges had been escalated or if they were being addressed.
- The staff within dental services felt they had been well supported and given all the necessary information about the changes to the service as a result of a recent tendering process.

Culture within this service

- Staff felt there were still differences in culture across the trust, based on historical and geographical factors. This was described by some staff as a 'them and us' culture. Staff commented that they collaborated effectively as a team, and most expressed a view that they readily helped other teams when they were under pressure. However, we heard that sometimes there was a lack of cooperation to support other teams.
- Some teams felt there was a disparity in management style with some managers encouraging staff involvement, and others creating a less open and transparent culture. Staff had not raised this formally within the trust, although most were aware of a whistle blowing policy.
- School nurses said their skills were not being used fully, with the focus of their work being on immunisation, and this caused disappointment and frustration. School nurses recognised the lack of investment in their service compared with the health visitor service, and felt they were 'firefighting'.
- Community nursery nurses commented they felt valued by their colleagues, however, management arrangements were hierarchical and they felt overlooked, despite carrying additional responsibilities.
- There was a strong view amongst staff that they provided a good service because everyone had a passion to collaborate effectively to improve people's quality of life. Despite some of the problems associated with implementing two significant changes to the way

staff worked in the past year, with a new IT system and the launch of locality management. Staff had embraced these changes and recognised the potential for longer term benefits.

- Health visitors said they worked well with their colleagues and supported each other to meet the needs of their clients. They covered staff sickness and annual leave and bank staff were used when necessary.
- Where problems were encountered with integrated working, staff sought proactive solutions. For example, a specialist nurse for children in care in Poole resolved an issue with referring children to CAMHS, by discussion and agreeing a suitable solution.
- New staff said they felt welcomed, supported and liked working with their colleagues. We heard comments such as 'My confidence has increased', 'I feel safe in my role' and 'my manager makes us feel valued'.
- Staff appreciated that managers took account of part time working, for example by arranging meetings on different days of the week to facilitate attendance.
- There was an emphasis on working safely, with staff trained in lone working and how to minimise the risks of harm in difficult situations. Staff were also able to have coaching in safe driving techniques.

Public engagement

- The trust had restructured community services with the aim of improving services for people, with better integration. It was not clear how children, young people and families had been involved in this process.
- The Family and Friends Test, had been rolled out in December 2014. Evaluation forms were given out at health checks by health visitors and school nurses. The feedback was collated and results showed people held the services in high regard.
- Bespoke questionnaires had been devised by individual services. The enuresis service carried out annual surveys and again these were complimentary about the staff and the service. Children in care services surveyed young people and their carers for feedback and suggestions, which was positive, with some suggestions for improvement.
- Sexual health services had set up evaluation forms for children and young people, carefully designed to encourage feedback. All responses were monitored and they were very positive. Staff in sexual health and relationship education feedback to school students each year, including a section on 'you said, we did'. As a result of a survey for people using The Junction, the service has trialled extended opening hours.

Staff engagement

- Many staff felt empowered to influence and improve the services. This was particularly the case for staff in sexual health services. For example, the workers in Dorset Working Women's Project had implemented their own ideas to develop the service. Health visitors gave examples of where services had been tailored to meet local need. These included setting up baby and 'nurture' clinics and groups to support mothers with post natal depression.
- Enuresis staff had investigated new types of alarms, which were more discrete, and introduced them to the service.
- Staff had been engaged in the implementation of the new IT system. Some staff reported excellent training, but in other areas staff felt that the initial training had not been adequate and there was insufficient follow-on support. Task groups were in place to canvas opinion in how to improve the system and updates were planned.

Innovation, improvement and sustainability

- At a local level, the value and sustainability of some clinics had not been reviewed consistently. For example a sexual health outreach clinic was provided fortnightly at an army camp, even though attendance levels were low.
- Attendance rates at clinics were monitored, but it was not clear what action was taken to reduce 'did not attend' (DNA) rates to improve the efficiency of the service and outcomes for people. For example, monthly DNA rates for paediatric SLT appointment were between 1% and 14% over the past year, and in sexual health services they were 9-14%. Action to bring the rates down, for example by texting people to remind them of appointments, was not done consistently.
- Staff were involved in initiatives to improve the quality of care. As well is setting up clinics in response to local need, staff had acted in response to complaints and local pressures. The SLT service had received complaints relating to people's lack of understanding of the service.

Requires improvement

Are services well-led?

In response, the service had worked with Healthwatch to create an information pack that was relevant and useful for families, including care pathways and a feedback form.

- A student heath visitor was supported to put together a business case for a project to tackle obesity in infants. This innovation was facilitated by their manager and the student was preparing the programme with assistance from the practice development group.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care or treatment because · Persons providing care or treatment did not always have the competence and skills to do so safely. Regulation 12 (2)(c) · Medicines were not always kept safe in sexual health services. Regulation 12 (2) (g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: There were not sufficient numbers of school nursing staff to meet the requirements set out in the fundamental standards. Regulation 18 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems were not in place to · Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a) · Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b)

This section is primarily information for the provider

Requirement notices

Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation (2)(e)