Sheffield Children's NHS Foundation Trust

RCU

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)
RCUEF	Sheffield Childrens' Hospitals		S10 2TH
RCU02	Ryegate Childrens' Centre	<Placeholder text>	S10 2TH

This report describes our judgement of the quality of care provided within this core service by Community health services for children, young people and families. 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 Community health services for children, young people and families and these are brought together to inform our overall judgement of Community health services for children, young people and families

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated effective, caring, responsive and well led as good. Safe was rated as requires improvement. We rated this service as good overall because:

- Staff were aware of their responsibility to report incidents, they knew how to report incidents, near misses and accidents and were encouraged to do so. Learning from incidents was shared between teams. However, it was hard for service leads to identify trends with regards to incidents as reporting was paper based.
- Safeguarding processes were in place and there was a dedicated safeguarding team in place. Practitioners received safeguarding training. However, we were not assured that the computer system kept children safe but relied on practitioner's knowledge of the system.
- Care and treatment was evidence based with policies, procedures and pathways available to staff. There was good evidence of multi-disciplinary working. Staff were aware of their responsibilities with regards to obtaining consent.
- We observed staff treating people with compassion, kindness, dignity and respect. Feedback from children, young people and their families was positive.
- Services were planned to meet people's needs and the needs of different people were taken in to account. Practitioners were aware of the needs of the local population.
- Leaders were approachable, supportive and encouraged staff engagement. However, some staff felt that there was not enough information given to them at an unsettling time, due to service redesign.
- Staff knew the trust vision and values. Governance systems were in place to ensure delivery of good quality care.

However:

- Health visitor caseloads exceeded recommendations and not all areas were offering a face to face antenatal contact to all mothers as part of the core offer.
- There was no consistency across the trust with regards to records. There was a risk that practitioners did not have access to information in a timely manner.

Summary of findings

Background to the service

Sheffield Children's NHS Foundation Trust provided community services including Health Visiting, school nursing, safeguarding and looked after team, paediatric liaison team, Family Nurse Partnership (FNP), speech and language therapists, occupational therapists, physiotherapists and community paediatricians. The Helena Specialist Nursing team provided 24 hour nursing and palliative care in the community for a wide range of children and young people with neurodisabilities aged 0 to 19 years old.

Ryegate House offered respite care to children with neurological conditions. There were a number of specialist nurses that provided care to children in the community. They were based in the hospital and provided outreach services.

Prior to our inspection the FNP had been decommissioned and was due to end in October 2016. The Health Visiting and school nursing services were in the process of a service redesign and were looking at a 0-19 model.

Children and young people under the age of 20 years made up 23.8% of the population of Sheffield and 31.9% of school children were from a minority ethnic group. The health and wellbeing of children in Sheffield was mixed compared with the England average. Admissions to hospital for specific conditions such as asthma, injuries, substance misuse and mental health conditions were all lower than or similar to the England average, except for admissions for dental caries (aged 1-4 years) and A&E attendances (0-4 years) which were worse than the England average.

During our inspection we visited 11 different locations including Health Visiting teams, school nursing teams, the FNP, the safeguarding and looked after teams and therapy services. We visited Ryegate House and spoke with the Helena nursing team. We attended home visits and observed baby clinics with the health visiting teams. We attended immunisation sessions with the school nurses.

We spoke with 65 members of staff, ten parents and 10 young people. We reviewed 30 sets of records and two parent held child health records (red book). We held focus groups with health visitors, specialist nurses and school nurses.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott

Head of inspection: Julie Walton, Care Quality Commission

Inspection Manager: Cathy Winn, Care Quality Commission

The community inspection team consisted of two CQC inspectors, a health visitor, a school nurse and a paediatric speech and language therapist.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

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

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

We carried out an announced visit from 14 to 17 June 2016.

We spoke with members of staff and observed their practice in clinics, schools and homes. We spoke to young people and parents/carers. Records were reviewed.

What people who use the provider say

Children, young people and their carers all gave positive feedback. They felt they were listened to and treated with respect. Most of the people we spoke to said they did not know how to make a formal complaint but would talk to staff members.

Good practice

- The Helena Specialist Nurse Team were available 24 hours a day and seven days a week to provide care and support to children, young people and families. Children, young people and their family's individual needs and preferences were central to the planning and delivery of tailored services.

The trust had established paediatric palliative care simulation training.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider MUST ensure that electronic record systems enable staff to identify and assess risks to the health, safety and welfare of people who use the service.
- The provider should ensure people who use the service know how to make a complaint.
- The provider should aim to reduce health visitor caseloads.
- The provider should ensure staff within the Helena Specialist Nursing team are up to date with training in high-risk equipment.
- The provider should enable staff to have access to regular safeguarding supervision.

Sheffield Children's NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Health visitor caseloads exceeded recommendations. Not all women were offered a face to face antenatal contact due to workload pressures, but those with a recognised vulnerability were prioritised.
- School nurses had a high workload and had limited capacity to attend review child protection conferences. They had a 22.8% vacancy rate.
- Different services used different record systems. Some were paper based whilst others were electronic. Different electronic systems were used across services; there was not consistency across the trust. Where services were using the same electronic system, there were issues around accessing children's records that were not in the practitioner's locality. There was a risk that practitioners did not have access to relevant information in a timely manner.
- Referrals to social care were not followed up in writing using a standardised referral form. This had been a recommendation following the CQC Safeguarding and Looked after Children (SLAC) review carried out in October 2015. We were told a standard multiagency referral form had been agreed.

However:

- Staff knew how to report incidents and received feedback.
- Staff received safeguarding supervision and training in line with national guidance and were knowledgeable about their responsibilities regarding safeguarding vulnerable people.
- Medicines management was good with effective processes in place.
- Appropriate risk assessments were carried out.

Requires improvement

Are services safe?

- Children and young people under the care of the Helena specialist nursing team had advanced care plans, which included clear plans for management of sudden critical events.

Safety performance

- Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are in place. No never events were reported between April 2015 and March 2016.
- The service did not use the national safety thermometer tool for children and young people to monitor safety performance. Due to pupils attending school, Ryegate House did not routinely have children present during the day when scoring would take place.

Incident reporting, learning and improvement

- There were 95 incidents reported between April 2015 and March 2016. They were documented as low harm. Thirty-five of the incidents related to communication between the midwifery service and health visitors. Antenatal notifications from midwives to health visitors had been identified as a risk on the risk register. The midwives worked for a different trust and discussions had been undertaken between senior managers from both trusts. Staff told us that they met with midwives at GP meetings in order to discuss issues.
- One serious incident was reported. In the period October to December 2015 three patients in respite care at Ryegate House experienced respiratory arrests. Of the three, two later died with the third patient being admitted as an in-patient to the Trust for continued care and management before discharge home with parents. A root cause analysis was undertaken.
- We saw the root cause analysis. It identified the root cause, lessons learned and recommendations. Staff were able to tell us some of the recommendations from the investigation and we saw they were in place during our inspection, for example, a house mobile phone for staff and clocks in every room.
- Incident reporting was paper based. Service leads told us that it was difficult to identify any trends with regards to incidents as they did not use an electronic system of reporting.
- An up to date appropriate incident reporting policy was in place. Staff we spoke to told us of the process they would follow and were aware of their responsibility to report incidents in line with the policy.
- Learning from incidents was fed back to staff through team meetings and emails. Some staff we spoke to did not feel they received feedback about incidents affecting other professional groups in the trust unless there was an issue relevant to their service.
- Staff within the Helena Specialist Nursing team and the Paediatric Oncology Outreach Nursing Service met weekly with the teams at the local children's hospice. Incidents were discussed at this meeting to support shared learning. Minutes from governance and risk management meetings were reviewed. Incidents were a standing agenda item.
- Mortality and morbidity was discussed at monthly South Yorkshire paediatric palliative care open meetings, chaired by the lead consultant for palliative and end of life care and attended by oncology consultants, the Helena Specialist Nursing team and the Paediatric Oncology Outreach Nursing Service.

Duty of Candour

- Staff we spoke with were aware of the Duty of Candour and the need to be open and honest with service users and their families. The intention of the Duty of Candour is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.
- We saw a letter that had been sent to a family from the school nursing service acknowledging that they had weighed and measured the child when the parents had opted out of the programme. An apology was given and the family informed of actions that would be taken.
- In Ryegate House, we saw evidence on an incident form in a patient record that parents had been informed of an incident involving their child.

Safeguarding

- The trust had a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2013). However, this statutory guidance was updated in 2015; the trust told us that staff had reviewed the updated guidance in 2015, but did not feel that this involved a significant change in practice. However, following our inspection the trust confirmed that it would now be updating its policy.Staff had received training on female genital mutilation (FGM) and child sexual exploitation (CSE). FGM (sometimes referred to as female circumcision) refers to procedures

that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK. CSE is a form of sexual abuse that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity.

- All staff we spoke to were aware of their own responsibilities and how to raise concerns. Referrals to social care were done over the phone with a letter to follow up. However, there was no standard referral template which meant that practitioners were not appropriately supported to analyse or articulate risks or concerns. This issue had been highlighted in a CQC Safeguarding and Looked after Children (SLAC) review carried out in October 2015 with a recommendation that all referrals to social care should be followed up in writing using a standardised referral form. We were told that this had not been implemented because initially social care did not agree to have a standard referral form. However, an agreement has now been reached to have a multi-agency referral from for all agencies.
- GP's that were not on the same computer system received a monthly list of those children, registered with their practice, who were on a child protection plan.
- The safeguarding team included a named doctor and named nurse which complied with the recommendation in Working Together to Safeguard Children (HM Government 2015).
- The safeguarding team in the community was led by the named nurse who had strong links to safeguarding colleagues in the hospital and the designated nurse based in the Clinical Commissioning Group (CCG). The team contributed to audits and multi-agency events on behalf of the trust. Named and specialist staff were represented on the local safeguarding board and sub groups. We observed that this was evidenced in meeting minutes.
- Members of the safeguarding team attended multi-agency risk assessment conferences (MARAC) where information was shared on high-risk domestic abuse cases. The safeguarding team member fedback relevant information to the health visitor.
- A new model of safeguarding supervision had been introduced which was described as more robust, as it lent itself to appropriate audit and facilitated staff learning, reflection and development in respect of their safeguarding responsibilities.
- Health visitors, school nurses, paediatric liaison nurses and looked after children (LAC) nurses had supervision every 3 months in line with national recommendations. Figures provided by the trust showed that during January 2016 to March 2016, 100% of school nurses, paediatric liaison nurses and LAC nurses had safeguarding supervision within timescales. 86% of health visitors had supervision within timescales. Reasons given for those outside the timescale included sickness, annual leave, maternity leave and workload issues. When supervision was delivered later it was normally within a few days. The Family Nurse Partnership nurses had weekly supervision which included safeguarding.
- We saw evidence in the records we reviewed of safeguarding supervision being documented.
- The Helena Specialist Nursing team did not receive regular documented safeguarding supervision. Senior staff had received some safeguarding supervision sessions, although these were planned to become regular sessions. This would include supervision sessions for support workers.
- The computer system used a flagging system to indicate if a child was subject to a child protection plan or was looked after. This meant that practitioners were aware when they accessed a child's records if there were any safeguarding concerns.
- Records reviewed had evidence of comprehensive child protection reports completed and multi-disciplinary working to support the families was evident. Appropriate assessments had been undertaken and early help plans put in place where required. Appropriate communication and information sharing with other professionals was seen.
- Figures provided by the trust showed that compliance with safeguarding level 3 training was 78.9%, however this was for the community, wellbeing and mental health directorate as a whole. Separate data provided from the health visitors, school nurses and paediatric liaison nurses showed a compliance rate of around 89%. The Helena Specialist Nursing team had a compliance rate of 100% for safeguarding level 3 training. The trust target was 85%.
- Health visitors held large numbers of families with more complex or safeguarding needs. Figures provided by the trust showed that these ranged from six families per whole time equivalent health visitor in one area to 23 families per whole time equivalent health visitor in another.

Requires improvement

Are services safe?

- The paediatric liaison team focused on safeguarding children and promoting their wellbeing through effective two-way communication between hospitals, adult substance misuse services and health visitors and school nurses.

Medicines

- We observed arrangements for managing medicines that kept people safe. There was good maintenance of the cold chain. Cold chain refers to the process used for the safe transport, storage and handling of immunisations. Immunisations need to be kept within a certain temperature range from the point of manufacture to when they are used.
- An up to date vaccine transport and storage policy was available which clearly set out staff's responsibility for the safe transport and storage of vaccines.
- Ordering of vaccinations by school nurses was done in a timely manner and there was appropriate stock rotation.
- Staff received medicines management training and annual immunisation updates.
- We saw evidence that patient group directives (PGD's) were in use and up to date. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor (or dentist).
- All health visitors were nurse prescribers. There were also two qualified nurse prescribers within the Helena Specialist Nursing team with a plan to increase this by one annually. They told us they received updates through emails and at the yearly medicine management training sessions.
- At Ryegate House, although the medicines trolley was based in an area that was observed by staff and was locked, it was not secured to the wall in accordance with guidance from the Royal Pharmaceutical Society of Great Britain.
- Managers were working with pharmacy to move towards using children's own medication. The service rarely stored controlled drugs. We reviewed the records and saw the last time this had been used was 2013.
- There was a system in place to provide anticipatory medicines to children and young people, when required. For example, this was included as part of the end of life pathway. Anticipatory medicines are medicines which are prescribed when anticipating symptom control needs and enable availability of key medications in the child's home.
- Specific training on medicines was provided to support workers within the Helena Specialist Nursing team. The support workers completed the Ordinary National Certificate (ONC) medicines management programme at level 2. Ten support workers had completed the course and a further five were currently undertaking the course.

Environment and equipment

- All equipment seen had been electrical safety tested and scales were regularly calibrated.
- All premises visited were child friendly and suitable for the purpose intended. Internal and external environments were clean and well maintained.
- Access to Ryegate House was secure via an intercom system; CCTV was in use outside. The garden had been developed from donations and volunteers, there was level access, seating and a wheelchair swing.
- The service had toys, sensory lights and other activities.
- All rooms had ceiling track hoists and electric beds. Staff had access to a mobile hoist if it was needed. The service had two adult cots.
- Therapy services had access to a bespoke equipment production department.
- All services had access to equipment they needed and staff reported that equipment was fixed promptly.
- Ryegate House had a process for separating and disposing of waste.
- Staff at Ryegate House had access to a grab bag which contained emergency resuscitation equipment. The grab bag was sealed and checked daily, records for this were complete.
- All registered nurses in the Helena Specialist Nursing team had undertaken training on the McKinley syringe pump. There was also a step-by-step guide to support nurses using the equipment.
- Records from May 2016 showed 52.3% of staff within the Helena Specialist Nursing team were up to date with training in high-risk equipment. This was below the trust's target of 85%.
- Where care was provided in family homes, environmental risk assessments were undertaken as part of the care provided.

Requires improvement

Are services safe?

Quality of records

- Different specialities within the community used different record keeping systems. Health visitors, school nurses and the FNP used electronic records whilst therapy services, the Helena Specialist Nursing team and Ryegate House used paper records.
- We were not assured that the electronic records system ensured that relevant information was shared in a timely manner, but relied on practitioner's knowledge of the system. The electronic system used different units for each locality. In order for practitioners to find a child on the system they needed to know which unit the child was registered under or had to go through child health. The paediatric liaison team could only see tasks sent to them if they had accessed the relevant unit that had sent the task. There was therefore a risk that practitioners did not have access to relevant information in a timely manner.
- Speech and language therapy staff used paper records and told us that at times they would take records home overnight. We were told that they had a service policy for this to ensure they signed out the notes on a tracer card and kept the records secure.
- Records we reviewed were accurate, legible and up to date in line with national guidance. They were stored securely. We saw evidence of the voice of the child in the records.
- Records reviewed at Ryegate House and for the Helena nursing team contained individualised care plans that were reviewed regularly.
- Health visitors were observed completing information in the parent held child health record (red book).
- Record audits were undertaken yearly. Clear action plans were seen in response to findings.

Cleanliness, infection control and hygiene

- We observed staff using appropriate hand hygiene techniques in clinic settings and on home visits. Bare below the elbows practice was adhered to. Hand washing facilities were available in every room at Ryegate House.
- Premises we visited were visibly clean.
- At Ryegate House, the ward kitchen checklist included all appropriate checks and was completed daily.
- We reviewed records for day tasks, night tasks and weekly patient environment checks. These tasks included tap flushing, cleaning of toys, blood glucose monitoring machine, fridge temperatures and other checks. All records were complete.
- Staff received infection control training. The community, wellbeing and mental health directorate had a compliance rate of 82% against a trust target of 85%.
- Hand hygiene audit results for health visitors showed an overall compliance of 99% for the year. Results for Ryegate House showed 100% compliance over the year.
- An environmental audit at Ryegate House in April 2016 scored 94%, meeting the required target of 85%. Any areas noted as not being compliant had an action noted against them.
- The portfolios for support workers working in the Helena Specialist Nursing team included cleanliness and infection control tools and competencies.

Mandatory training

- Training available included infection control, information governance, fire safety and basic life support.
- Managers received monthly updates of staff training compliance. Staff were encouraged to complete required training.
- The trust target for mandatory training was 85%. Data supplied by the trust showed compliance varied greatly between practitioners with some achieving 100% whilst others were as low as 33%. On average, training compliance for community was around 85%.
- Staff told us that there were some delays in their training being registered on the system; sometimes they received notification that they were out of date with their training when they had completed it.
- Staff told us that they had time to complete their training. Staff from Ryegate House completed mandatory training annually on a day the service was closed.

Assessing and responding to patient risk

- At Ryegate House, staff completed a safe environment care plan that recorded the observation of children at least hourly overnight. This included checks such as skin colour, pressure care, pain, mood and monitoring of

overnight feeding. The service followed a deterioration of condition care plan and staff knew to call an ambulance to transfer the child to the main hospital site.
- Staff told us they could contact medical staff at the main site for advice if needed.
- A tracheostomy life support algorhythm was available to staff at Ryegate House.
- The Helena Specialist Nursing team had individualised care plans. We saw that they included detailed care planning and the management of a sudden critical event.
- Where limitation of treatment agreements were in place, the ambulance service were made aware of these.
- Risk assessments were in place. This included risk assessments for activities that children at the end of life were supported to do, such as water-based activities.
- The Helena Specialist Nursing team and the Paeditaric Oncology Outreach Nursing Service (POONS) team had an on-call service which covered the out of hours period.
- Helena Specialist Nursing team staff undertook palliative and ventilation simulation days. They also attended the trust training day for recognition of a deteriorating child.
- Health visitors and school nurses told us that they met for a face to face handover on complex, vulnerable families.
- We saw evidence in health visitor records of assessments undertaken using the Family common assessment framework (FCAF). This allowed for early identification of additional needs.
- Staff were encouraged to complete ongoing chronologies of significant events to form an ongoing risk assessment. Work was ongoing to ensure staff kept records up to date with regards to new people in the household. This was in response to a serious case review which identified that documentation did not contain up to date household members.
- School nurses undertook risk assessments prior to immunisation sessions in order to identify the member of staff responsible for any emergency help needed during the session.
- Therapy services had risk assessment forms which were completed for specific treatments.

Staffing levels and caseload

- Health visiting managers used a caseload weighting tool based on the indices of multiple deprivation. Deprivation indicators are used to describe the level of poverty or disadvantage in an area.
- Caseloads were regularly discussed at weekly team leader meetings. Numbers on the caseload were examined and how teams were coping. Risk assessments had been completed in some teams to identify staff shortages and prioritise the workload. Staff members were moved between teams when necessary.
- Lord Laming in; “The Protection of Children in England: A Progress Report” (March 2009) recommended that caseloads should not exceed 400 children per whole time equivalent health visitor. Half of the health visiting teams in the city were exceeding this recommendation. The highest caseload in the city had 613 children per whole time equivalent health visitor.
- Due to staffing levels and workload, health visitors in some teams were not offering antenatal contacts to every pregnant woman, but prioritised those with recognised vulnerabilities. Vacancy levels were at 5.5%. Eight posts had recently been recruited to from HV students due to qualify.
- Feedback from staff suggested that in some areas of the city they were only able to offer the core contacts whilst others were offering more, such as weaning groups.
- The Family Nurse Partnership nurses had 25 families each. This was in line with The Family Nurse Partnership Core Model Elements recommendations.
- At Ryegate House, they did not use a dependency tool to plan staffing, however, there was a plan to develop one. A timescale for this was not available at the time of the inspection. The registered nurse establishment was for 235 hours a week. Recruitment was underway for one 25 hours vacancy.
- Ryegate House was staffed with one registered nurse and two support workers in the day and one registered nurse and one support worker overnight. All registered nurses, apart from two, were children’s nurses. The service regularly used substantive staff working bank shifts and regular bank staff. Staffing was not flexed to need so the children offered respite was changed rather than staffing numbers. This wasn’t a robust system, it relied on staff having knowledge of the children rather than formal dependency.

Requires improvement

Are services safe?

- School nurses had high workloads and had limited capacity to attend child protection conferences. They attended initial conferences and would attend review conferences if there was an identified health need.
- School nurses had a 22.8% vacancy rate as at 29 February 2016.
- Locum usage for community paediatrics in 2015 ranged from 57.2% in July 2015 to 0% in October 2015.
- The Helena Specialist Nursing team consisted of two band 7 registered nurses (a team leader and clinical educator), eight band 6 and one band 5 registered nurses. A team of approximately 50 band 3 support workers supported them.
- Staffing levels for this team were based on the assessed needs of the children on the caseload. Commissioners predominantly provided funding for each individual child or young person; this meant the appropriate staffing levels were in place for each individual.
- The team were supported by a consultant lead for palliative care and paediatric intensive care who provided medical care across the acute hospital and the community. They held a joint appointment with the local children's hospice and spent approximately one day a week providing care to children in the community.
- A member of junior medical staff, who was a GRID trainee, supported the consultant paediatrician.

Managing anticipated risks

- Each service had a business continuity plan in place.
- Staff had been provided with lone working devices. Staff signed in and out of bases. Visits were conducted in pairs if there was an identified risk.
- The Helena Specialist Nursing team had an on-call system so staff had a contact in case of any issues, such as staffing shortages or concerns raised during a visit.
- Health visitors and school nurses could document on the electronic record system an alert to inform other practitioners of any potential risks in a household, for example domestic violence.
- Staff were able to tell us about winter management plans, such as attending their nearest base if possible.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Care was provided in line with national guidance, such as National Institute for Clinical Excellence (NICE) guidelines. Staff had access to policies, procedures and pathways, although some were due for review.
- The service provided the Healthy Child Programme (HCP), National Child Measurement Programme (NCMP) and Family Nurse Partnership (FNP) programme.
- The trust had achieved stage 3 in the UNICEF Baby Friendly Breastfeeding accreditation.
- Services were meeting outcome targets. There was an annual audit programme in place.
- Our observation of practice, review of records and discussion with staff confirmed effective multi-disciplinary team (MDT) working practices were in place. There were processes in place for referrals and transition. Staff were aware of their responsibilities with regards to obtaining consent.

Evidence based care and treatment

- Services had achieved UNICEF baby friendly stage 3.The UNICEF baby friendly initiative is a national intervention that has been found to have a positive effect on breastfeeding rates in the UK.
- The trust had a Family Nurse Partnership (FNP) team. FNP is a voluntary health visiting programme for young and first time mothers. It is underpinned by internationally recognised evidence based practice. However, the service had recently been decommissioned and was due to end in October 2016.
- The trust had a looked after children team which provided extra support to children who were looked after based on the Department of Health document 'Promoting the health and wellbeing of looked after children' (2015).
- Health visitors were trained in and used the Solihull Approach. The Solihull Approach is an evidence based model that promotes emotional health and wellbeing in children and families.
- A number of health visitors were trained in the Newborn Behavioural Observation System (NBOS) and the Newborn Behavioural Assessment Scale (NBAS).The NBOS is an interactive and family-centred tool designed to develop and foster positive parent-child relationships. The NBAS looks at a wide range of infant behaviours that help to develop appropriate caregiving strategies.
- Care was provided in line with national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines. Staff had access to policies, procedures and pathways.
- Nursery nurses were trained in 'health exercise and nutrition for the very young' (HENRY) a national evidenced based programme.
- The service provided the Healthy Child Programme (HCP) and National Child Measurement Programme (NCMP). The HCP is an early intervention and prevention public health programme offered to every family and is an opportunity to identify families in need of further support. The NCMP measures the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children within primary schools. The NCMP was set up in line with the Government's strategy to tackle obesity.
- Health visiting teams used the Ages and Stages Questionnaire (ASQ). ASQ is an evidence based tool that helps to identify problems in children's development allowing for effective early intervention.
- During observation of practitioners, we saw advice given based on up to date evidence with regards to issues such as weaning and sleep.
- The Helena Specialist Nursing team and Ryegate House nursing team used evidence based pathways and care plans produced by the trust. However, six out of ten that we looked at were out of date for review, although the practitioners were working to current national evidence based guidelines.
- Children with long term conditions or complex needs had clear personalised care plans which were in line with relevant good practice guidance.

Good

Are services effective?

- Ryegate House used a criteria assessment rating. This document did not contain a publication date, references or a review date.
- NICE compliance and policies were seen as a standing agenda item on clinical governance meeting minutes.
- Staff we spoke with in the FNP, health visiting, school nursing and therapy teams were aware of the national guidelines relevant to their area of practice. They were supported by the service leads to follow this practice.
- Health visitors used recognised post-natal depression screening tools.

Pain relief

- Pain was assessed and plans were in place to meet individual children's needs.
- Distraction and repositioning were used as part of the strategies for pain relief.
- Anticipatory medicines were available, where appropriate, to support pain management.

Nutrition and hydration

- Health visitors performed breastfeeding assessments at the primary birth visit.
- Body Mass Index measurements were assessed universally at 2 years and then at 5 years and 11years as part of the National Child Measurement Programme with children identified as being overweight and obese being referred to targeted services.
- At Ryegate House, there was a dining area, however, staff explained this was not regularly used as most of the children were gastrostomy fed. Support workers completed a gastrostomy training package and the child's usual feeding schedule was followed.
- Training was available for staff on the use of feed pumps to support those children who were tube fed.
- Patient records identified nutritional needs.

Technology and telemedicine

- The Family Nurse Partnership had a Facebook page. This had been set up in response to requests from clients. The trust also had a Facebook page which practitioners said they could access to post items on.
- The Family Nurse Partnership regularly communicated with their clients through text messages.

Patient outcomes

- The health visiting service was in communication with commissioners around flexibility in the timescales for their delivery of the HCP as there was a risk of failure to deliver the HCP due to workloads.
- Data provided showed that between October 2015 and December 2015, 88% of birth visits were done within 14 days against an England average of 87.7%. Reasons for visits not done within the timescale included babies who were still in hospital, parents cancelling appointments and families requiring specific health visitors.
- 95% of babies received a six to eight week visit by the time they were eight weeks old. The England average was 80.7%.
- 93% of children received a 12 month review by the time they were 12 months and 90% of children had received a two to two and a half year assessment. These were higher than the England average.
- The rate for babies breastfeeding at six weeks was 50% which was above the England average of 42.2%.
- The school nursing service had achieved a total of 87.1% for uptake of the HPV vaccination for year eight pupils and 93.5% for year nine pupils against a target of 90%.
- The therapy services had a research steering group which planned projects and research and supported staff to engage in audit and evaluation.
- The FNP had a goal of 60% of clients to be enrolled before 16 weeks of pregnancy. The FNP annual report 2104/2015 showed they had achieved 46.3% in 12 months. The FNP supervisors told us that having overcome the problems with communication from midwives, they thought their results would now be higher.
- The paediatric liaison team had not done any audits since July 2015due to staffing.
- Speech and language therapy developed targets around the child and reviewed whether those targets had been reached. They measured the level of errors in a child's speech. Outcomes were used in order to alter the service they delivered.
- Occupational therapy and physiotherapy used a process of clinical outcomes, audit, service user feedback and evaluation.
- For the Helena Specialist Nursing team clinical outcomes were based upon the individual experience of children, young people and their families.The team provided examples of how they had monitored the individual outcomes for the child or young person and

their family. This included the consultant routinely inviting all families to have a follow-up visit following a child's death. This was so the family could ask any questions they may have and explore any issues or experiences that families wished to talk about.

Competent staff

- Staff performance was managed through appraisals. Appraisal rates for the directorate were 66.6% overall. It was not clear from the data provided what the trust target was.
- Staff told us that they received regular supervision and we were told that all had achieved 100% apart from one health visiting team, however data was not recorded formally.
- The health visiting service and school nurses followed a competence framework for new starters which covered the core aspects of their role.
- Newly qualified speech and language therapists held smaller caseloads and followed frameworks for training. They would have a preceptorship period, have weekly supervision for the first term and have a nominated buddy.
- Staff had access to extra training relevant to their role. For example, health visitors had motivational interviewing training and perinatal mental health training.
- The Helena Specialist Nursing team had a profile of learning needs and competencies which included ventilator, tracheostomy and gastrostomy training.
- The Helena Specialist Nursing team had a nurse educator to support training and development. Within the team, one nurse was due to start an advanced nurse practitioner course in September 2016. This would include advanced clinical assessment modules to enable staff to provide additional care for children, such as physical assessments.
- Speech and language therapists had specialists in cleft lip and palate, disfluency and dysphagia.
- Nursery nurses had been trained in accident prevention and health exercise and nutrition for the really young (HENRY), in order to provide extra support to families.
- School nurses attended school nurse development days held once or twice a year. During this day they received updates on relevant issues, such as the national child measurement programme and flu vaccine. They also received feedback from specialist community public health nursing students.
- Practice teachers held bi monthly training for health visitors to attend. This ensured they were kept up to date with issues relevant to practice.
- At Ryegate House, we reviewed a file that contained completed bank staff induction lists.

We reviewed two staff files, both contained up to date appraisals with development objectives, mandatory training records and competency books.

- Support workers at Ryegate House completed the trust home to hospital competency book. They told us that other healthcare professionals provided training on equipment or interventions children required.

Multi-disciplinary working and coordinated care pathways

- The health visiting and school nursing services were in the process of a service redesign with a view to having an integrated 0-19 service.
- The Helena Specialist Nursing team worked closely with schools. They went in to schools to deliver care to patients and trained the school staff as appropriate, so that when the nursing staff had a break the child's care could continue.
- A psychologist was part of the Helena Specialist Nursing team.
- Multidisciplinary meetings were held at the local children's hospice and attended by members of the Helena team, POONs and the lead consultant.
- Health visitors had six weekly meetings with GP's and midwives to discuss more vulnerable families.
- Health visitors worked closely with the children's centres. Some of the baby clinics were held in the children's centres. Children's centre staff could make referrals to the health visiting teams although they did not have a specific referral form to use.
- Health visitors attended children centre advisory board meetings and stakeholder meetings.
- School nurses had good relationships with schools including religion-based schools.
- School nursing teams were co-located with a multi-agency support team (MAST) who supported vulnerable families. This co-location meant there was good communication and liaison.
- The family nurse partnership had good links with other agencies. They worked as advocates for their families,

looking at all the issues surrounding the family and supporting them. They worked in partnership with others such as the sexual exploitation team, looked after children team, smoking cessation and housing.
- The looked after team had strong professional networks with other services across the city. The interaction with social care was in a period of fluctuation due to changes in social care structures and staffing. A group that looked at the health and wellbeing of looked after children in the multi-agency arena was on hold while these changes took place.
- Therapy services worked as part of a wider multi-disciplinary team.
- At Ryegate House, staff told us there was good teamwork and communication within the multidisciplinary team. We observed this during our inspection.
- All of the records we reviewed had evidence of input from the multidisciplinary team.

Referral, transfer, discharge and transition

- The looked after team received referrals from the paediatric liaison nurses via email. Information was provided such as domestic violence, sexual exploitation and self harm.
- Occupational therapy had a clear referral pathway. They accepted referrals from consultants and GP's.
- School nurses contacted parents of children moving from year six to year seven in special schools to obtain the most up to date health information and shared this with the schools.
- For older looked after children, the school nurses liaised with the looked after children's team. They attended the annual review in school and liaised with other professionals in order to pass on relevant information to adult services.
- A transition policy was in place for the transfer of children from health visiting to school nursing. Verbal handovers would be given for those more vulnerable families.
- All care leavers received a health care summary from the looked after team. We saw that this included public health leaflets and a copy of the final health care plan. A copy of this was sent to the GP.
- The FNP had a transfer pathway to health visitors. They used summary sheets to hand over and assessed clients on an individual basis. Some families received a joint visit between the family nurse and the health visitor.
- Ryegate House accepted referrals from all members of the multidisciplinary team, school staff and parents.
- Staff told us there was good communication with adult services. Support workers and nurses from adult respite services contacted Ryegate House and visited prior to transition but there was no formal process in place at the time of our inspection.
- Referrals were accepted to the Helena Specialist Nursing team from various services including the maternity hospital and out of area referrals. A weekly referral and assessment panel meeting took place to discuss admissions to the service.
- Within the neurodisability service, there were pathways available for transition. Teams worked closely with the transition team at Ryegate House, which offered respite care.

Access to information

- The community service did not have a fully integrated multi-disciplinary team case note record as some services used an electronic patient record, whilst others used paper records. This may mean practitioners did not have access to up to date information from other services.
- The looked after children team used paper records; they could access electronic records as read only, but could not input any data on there.
- Health visitors and school nurses each had a laptop in order to access electronic records.
- School nurses accessed the electronic records during immunisation sessions to check the child's immunisation status and prevent duplication of immunisations. All immunisations were documented on to the system within 24 hours of being given.
- For those GP's not on the same system a paper copy of the child's immunisations were sent within a week.
- For the Helena Specialist Nursing team, each child had a care record accessible to staff. There was a system in place to record and hand over the care of each child. The key workers were responsible for updating the information, printing, and signing it to include it in the child's nursing notes.

Consent

- Staff we spoke with were aware of Gillick competency. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Good

Are services effective?

- School nurses used Gillick competency to allow children to consent when parents had not completed consent forms. Staff were observed at an immunisation session discussing consent over the phone with the parents and with the child at the session. They gave examples to us of when they had not vaccinated as they were not assured that the child was competent.
- Within the family nurse partnership, consent was obtained formally as patients signed an agreement to join the programme. Parents were given clear information prior to giving their consent.
- The looked after children team had reviewed their paperwork and separated age groups in to 0-5, 6-11 and 11-18. For the over 11's, they had included consent and the opportunity to be seen alone.
- The records we reviewed at Ryegate House and with the Helena Specialist Nursing team contained signed consent forms.
- Children and young people under the care of the Helena Specialist Nursing team had advanced care plans in place. Where appropriate, limitation of treatment agreements were made with the children and families. Staff using these, demonstrated a good understanding of the Mental Capacity Act.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff were observed to be caring and compassionate and were able to provide children, young people and their families with emotional support.
- Children, young people and their families were involved in their care. Practitioners ensured that families were involved with the planning and delivery of care.
- Children and families who used the services felt listened to. They told us that they felt supported and staff were approachable and helpful.
- Verbal feedback we received from parents and young people was positive.
- Staff, particularly within the Helena Specialist Nursing team, were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff recognised and respected children and their family's personal, cultural, social and religious needs and took these into account.

Compassionate care

- Practitioners were observed to interact with children and young people in a calm, friendly and respectful way.
- School nurses at an immunisation session offered a screened, more private area if any child needed to remove their top for the immunisations.
- Staff were seen to respond in a caring and compassionate way, comforting children who were very anxious about having immunisations. Extra time and attention was given to ensure they were supported through the process.
- Children with special needs were provided with appointments to be seen at the end of the clinic to ensure they had a calmer, quieter atmosphere with less people around.
- Parents we spoke with said that they valued the visits from the health visitor and felt advice offered was appropriate and helpful.
- Young people that we spoke with told us that the school nurses were helpful and treated them with respect.
- Staff supported families in vulnerable circumstances, helping them with issues such as housing, financial support and seeking asylum.
- Friends and Family data was limited. For example, in January 2016, 32 responses were received by the health visiting service and two by the FNP. All responses received were positive.
- Comments seen from the Friends and Family test feedback received in 2015 were mainly positive.
- Staff were committed to ensuring they gave the best service they could to the families despite the pressure of workloads.
- The Helena Specialist Nursing team described how they got to know the families very well over time. They gave examples of being invited to other significant family events, which demonstrated a close relationship.
- The Helena Specialist Nursing team members that we spoke with demonstrated a compassionate, family-centred approach to the children and families in their care.
- Feedback from patients and carers about the care provided by the Helena Specialist Nursing team and lead consultant was very positive.

Understanding and involvement of patients and those close to them

- Practitioners were observed giving clear explanations to children and young people at a level they could understand.
- The Helena nursing team and Ryegate House worked in partnership with the families in developing plans of care. The team and the lead consultant were clear that the control of the child's care was always with the child and family.
- The team taught parents how to perform care themselves, where appropriate. Parents that we spoke to said they were happy with their level of involvement and with the information provided to them.
- We heard of examples where children and young people were supported to 'have fun' and be involved in activities, such as helicopter rides.
- We observed children at Ryegate House dressed in their own clothes with personal blankets and possessions.

Emotional support

Good

Are services caring?

- Practitioners used motivational interviewing techniques in order to empower families to manage problems and difficulties.
- School nurses were observed engaging with young people and listening empathetically to their concerns. They ensured time was given to those young people that needed extra support.
- The Helena Specialist Nursing team provided emotional support to the families of children with life limiting conditions. A psychologist was part of the team. This support continued after the child had died.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Care was provided in clinics, schools and homes. Baby clinics were provided in various locations.
- School nursing teams had responded to a low drop in session attendance in schools by working in partnership with community youth teams to offer sessions in youth clubs.
- Practitioners recognised the needs of their local population, such as the high level of Roma Slovak community.
- The paediatric liaison team provided a link between health visiting and school nursing teams and other services.

However:

- Children with autism had up to a five month wait for therapy services.
- Information was not routinely provided about how to make a complaint and families we spoke to said they were unaware how to make a formal complaint.

Planning and delivering services which meet people's needs

- The service was looking at a redesign to a 0-19 service, with integrated working. Service leads planned to engage with families to consider their views.
- The health visiting service held baby clinics in various locations across the city to meet the needs of the local population.
- School nurses in the east had developed drop in and health promotion sessions, in partnership with community youth teams, which they held in youth clubs. This was in response to poor attendance at drop in sessions at schools. Children from across the city could attend these sessions and contact could be made with young people who were vulnerable, missing from education or considered 'hard to reach' on child protection plans.
- School nurses in the north had reduced their after school drop in sessions due to lack of attendance, but had increased their visibility in schools by offering a full morning session during school time.
- School nurses had an 'educated at home' protocol to ensure that those children were offered the same service as those in school.
- The looked after children's team arranged clinics to take place after school and could arrange alternative venues to their normal one if required.
- Each health visiting team had a duty worker on each day. This practitioner was available in the office during the day to deal with any issues that arose rather than having to wait until the named practitioner returned to the office, meaning calls from parents, social workers and other practitioners were dealt with straight away.
- Health visiting teams had a team that worked with the Roma Slovak community. This team has presented citywide to other health visiting teams about the needs of the Roma Slovak community.
- Speech therapists held a weekly session called 'toddler talk', a group for children two to two and a half years old who were not talking or had less than 50 words.
- Therapists and specialist nurses visited children at Ryegate House if they were in respite at the time they had a clinic appointment. Clinic staff taught new programmes to staff at Ryegate House and offer equipment and activities for children.
- The Helena Specialist Nurse team worked closely with commissioners of the service and met regularly with them.
- The Helena Specialist Nursing team, POONS, and lead consultant met weekly at the local children's hospice to plan and discuss care plans and admissions to ensure that the children's needs were met.
- The Helena Specialist Nursing team service was provided 24 hours a day and seven days a week to enable children and young people to be cared for at home if they chose.

Equality and diversity

- A risk had been identified with interpreting services. A change of interpreter provider had caused issues, such as wrong language interpreters arriving and interpreters of the opposite sex to those that had been booked. The issues had been escalated to the trust managers by practitioners.

Good

Are services responsive to people's needs?

- The school nurses in the west of the city had established information café's in three primary schools for migrant families. These sessions offered discussions around children's health care and education provision in this country.
- School nurse information was translated in to a number of different languages.
- The trust intranet had leaflets for issues such as head lice and common illnesses that were written in Roma Slovak. Staff were observed providing leaflets written in Slovakian about how to access health services.
- School nurses provided services in Islamic schools, recognising cultural and religious differences.
- Speech and language therapists used resources that were bigger than average for those children with a visual impairment.
- Services provided by the Helena Specialist Nursing team, were planned to take account of the needs of different people, for example on the grounds of age, disability, gender, and religion or belief. Parents we spoke with confirmed that their culture was taken into consideration when planning and delivering care . For example, when it was Eid, the service was sensitive about it being a special time for families and were careful to be as low key in their visiting as was possible.

Meeting the needs of people in vulnerable circumstances

- The FNP offered support to vulnerable, young mothers. This service had been decommissioned and service leads told us they were looking at a vulnerable care pathway to use with the 0-19 service.
- The looked after children's nurses visited young people at home prior to their initial health assessment for health promotion, promoting engagement with the young people in the health assessment process.
- Practitioners could refer to multi-agency support teams (MAST) which consisted of child and adolescent mental health workers (CAMHS), social workers, prevention workers and intervention workers. They were available to support families that required extra help.
- School nursing numbers were low, therefore health visitors were working with schools if there was a younger child in the family and there were safeguarding or complex needs. This facilitated continuity of care and maintained a familiar professional for the family to work with.
- The paediatric liaison team included a substance misuse liaison nurse and a dental liaison nurse. These post were developed following serious case reviews. They had developed a pathway for vulnerable children to access dental treatments in recognition of the high levels of dental caries in children under four years.
- Children and young people receiving care from the Helena Specilaist Nursing Team had complex needs. The plans of care were tailored to the individual to ensure their needs were met. We saw examples of individualised plans of care that had been developed with the child and family.
- Within the service, each child had a named key worker to provide continuity. Parents we spoke with confirmed that the service tried to provide the same staff, where possible.

Access to the right care at the right time

- The NHS constitution (2010) states that people with a referral from a GP should start their treatment within 18 weeks. The target is that at least 92% of people should spend less than 18 weeks waiting for treatment.
- Community paediatrics were meeting this target. Data provided showed that in April 2016, 95%were seen within 18 weeks and in May 2016 96.7%were seen.
- Data provided by the trust regarding community speech and language therapy showed that between April 2015 and March 2016 an average of 51.8% of children were seen for initial assessment within 12 weeks, the average waiting time was 11 weeks.
- Speech and language therapists offered nine drop in sessions across the city facilitated by health visitors.This meant that advice could be offered immediately while waiting for a referral.
- Waiting times in May 2016 for occupational therapy and physiotherapy ranged from eight weeks for mainstream physiotherapy to 32 weeks in special schools occupational therapy.
- Children with autism had up to a five month wait for therapy services. Parents were informed of this wait and attendance at workshops were offered prior to the appointment.
- The Helena nursing team provided 24 hour respite care within the child's home if required. They also provided an on call system.

Good

Are services responsive to people's needs?

- The Helena Specialist Nursing team provided care to children and young people with complex needs. The team identified changing needs and had conversations with families to ensure they understood and received the right care.
- Ryegate House offered respite to children between two and nineteen years of age who were under the care of a neurology consultant, had complex health problems and required nursing care. At the time of our inspection, it was open six days a week. We were told that the service was able to meet the number of commissioned places for children and young children by offering the service six nights a week. The day it did not offer the service allowed the department to ensure appropriate training and development could be achieved.
- Respite care was planned in three month blocks. The service worked flexibly to offer respite care at short notice if it was available.

Learning from complaints and concerns

- Families that we spoke with said they did not know how to make a formal complaint, but they would discuss it with practitioners if they felt they needed to.
- We did not see any information displayed in clinical areas to inform people how to make a complaint.
- Practitioners told us that if someone wanted to make a complaint they would encourage them to contact the manager. They would give out a complaints leaflet if the person wanted to take it further.
- Staff were able to describe complaint procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.
- The Patient Advice and Liaison (PALS) officer worked directly with parents to help to resolve any issues at an early stage.
- Staff in therapy services were able to tell us of a change in practice as the result of a complaint regarding the handover process from early years to school age teams.
- There were nine formal complaints received between April 2015 and March 2016. One was later withdrawn. A common theme to these complaints was staff attitude and communication. Four of these complaints were upheld and action taken was documented.
- Complaints were a standing agenda item at clinical governance meetings in order to discuss lessons learned.

Good

Are services well-led?

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

Summary

We rated well led as good because:

- There were effective governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded between senior management and clinical staff.
- Managers were approachable and supportive.
- Staff were given opportunities to share their views and provide suggestions, although some said that workloads prevented them from accessing engagement events.We saw examples where the leadership drove continuous improvement and innovation. This was recognised nationally.

However:

- Most staff said they did not see the executive team. At an unsettling time staff were unaware whether the executive team were aware of the impact service changes would have on families.

Service vision and strategy

- There was no formalised vision or strategies for the services. Staff we spoke to were aware of the trust vision and values.
- The community directorate was looking towards more common strategic goals between the different services that reflected the trust vision and values.
- When we spoke to staff some of them felt that they were unsure how services would be developed and it was an unsettling time for them.
- Specialist nurses had been involved in discussing the development of a nursing strategy.
- Corporate objectives for the trust had been agreed for 2016/17. The objectives were set within the context of the trust's strategic objectives for 2011-16. These included a planned review of the neurodisability service. The Helena Specialist Nursing Team provided care predominantly to children and young people with neurodisabilities.

Governance, risk management and quality measurement

- Clinical governance and risk management meetings were held monthly.
- Governance arrangements for the Helena Specialist Nursing team and Ryegate House were part of the Medicine division's governance and risk management structure with effective systems to report to the board.
- Minutes seen from clinical governance meetings showed that standing agenda items included patient safety, clinical effectiveness, complaints, policies and information governance. Feedback was given from the trust quality board.
- Minutes from the risk management group included information such as security issues, health and safety, incidents and the risk register was reviewed.
- Feedback from governance and risk meetings was disseminated to practitioners through team meetings.
- The trust legal and governance team provided support and encouraged practitioners to undertake audits. There was a clinical audit and effectiveness programme in place for 2015/2016.
- Service leads identified their top risk as managing a safe service. Service leads were prioritising workload and working with the local authority and asking commissioners for flexibility to ensure ongoing delivery of services. Service leaders had also recognised that their school nursing numbers were low, recruitment was underway but the service was considering the redesign of the service to cover a 0-19 pathway, allowing for resources to be shared across the pathway.
- Risks identified on the risk register included antenatal notifications from midwives, ability to complete core offer and the new model of supervision. This was regularly updated. There was no record on the risk register of the problems identified with regards to accessing records of children in different localities.

Leadership of this service

- Not all services were in the community directorate. The Helena nursing team, Ryegate House, therapy services and the looked after team were in the medical directorate. This meant that the leadership and governance arrangements were different.

Good

Are services well-led?

- Staff spoke positively about their line managers and felt supported.
- Service leads told us they had an open door policy so that practitioners could access them at any time.
- Most of the staff we spoke to felt it was a good trust to work for and there were opportunities for development. However, some felt that they were so busy with their caseloads that there was no opportunity to do other things.
- All staff said they felt part of the wider trust. Historically, they did not feel part of the trust, but they felt this had moved forward.
- Nurses from the FNP said they were well supported by the managers, but felt that there needed to be more communication from the executive team at an unsettling time when they were being decommissioned. They were unsure how much the trust understood the impact that decommissioning the service would have on the families.
- Staff were able to access a leadership and management course run by external partners. Band five and six practitioners were encouraged to attend for their development.
- Some staff we spoke to in the health visiting teams were feeling demoralised and anxious regarding caseload demands and stress levels. They felt their leaders were supportive but they were anxious as to what would happen with the service redesign.
- Most of the staff that we spoke to said that they did not regularly see the executive team. However, specialist nurses had met with the Director of Nursing.
- The Helena Specialist Nursing team and Ryegate House were managed as part of the Medicine division. There was a matron with responsibility for the services provided across the acute hospital and the community provision.
- Leaders of the service had undertaken further study, for example, members of the Helena Specialist Nursing team had undertaken Masters degrees in palliative care.

Culture within this service

- Staff we spoke to were focused on the children and families that used their services. Many of them worked over their hours in order to provide the service and place the child at the centre of what they did.
- Staff felt there was an open, no blame culture where they felt supported to raise concerns.
- One member of staff at Ryegate House told us they felt supported through the serious incident investigation which included a debrief and chaplaincy support.

Public engagement

- School nurses held coffee morning for parents in school in order to engage with them more.
- The FNP had their own feedback forms that they gave to clients. They also used a client/FNP review form where they asked questions to establish how the relationship was working between them.
- Parents at Ryegate House were involved in the development work between the service and commissioners.
- The service sent parents a questionnaire after their child had been for respite.
- Friends and family feedback forms were given to the families.
- A survey had been carried out by an external organisation to gather feedback from families using the health visiting service. Staff told us that as a result of feedback from this they had started the weaning groups.
- The Helena Specialist Nursing Team recognised they could do more to engage the public. They had considered involving parents in recruitment and discussed having a parents group.

Staff engagement

- Staff told us they felt confident to suggest new ideas that they wanted to try and they would be listened to by managers.
- Some staff told us they had been consulted about the 0-19 service redesign and encouraged to put ideas forward whilst others told us that they did not feel they had enough information about it.
- Staff attended team meetings where feedback could be given about how improvements could be made.
- Staff received email bulletins to keep them up to date with trust news.
- Staff took part in the staff survey every year.
- Drop in sessions were held by the executive team but staff we spoke to said it was difficult to attend due to workloads.

Innovation, improvement and sustainability

- One of the health visitors had been appointed as research lead for the directorate.

Good

Are services well-led?

- School nurses had developed sessions in partnership with youth community workers.
- The Helena Specialist Nursing service provided simulation training. An article was published in the British Medical Journal in June 2016. This showed that based on confidence questions, attendees felt more confident in managing specific palliative scenarios
- Members of the Helena Specialist team were engaged regionally, nationally and internationally. The consultant had submitted papers to present at an international conference this year. Members of the Helena Specialist Nursing Team also attended the international conferences.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There was no consistency across the trust with regards to records. There was a risk that practitioners did not have access to information in a timely manner.