County Offices, Newland, Lincoln

Quality Report

County Offices,
Newland
Lincoln
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

County Offices, Newland, Lincoln provided health visiting and children and young people nursing services to children, young people and families in the county of Lincolnshire.

We found the following areas of good practice:

Staff recognised safety incidents and reported them appropriately. They were investigated and staff learned from them. Staff knew how to keep children safe and were trained to recognise and report abuse appropriately. Children's records were kept securely, and individual risk assessments were clearly documented. Contingency plans for the interruption of services were in place.

Services were based on national guidance with managers monitoring the delivery of the Healthy Child Programme and ensuring staff were competent to undertake their role. Staff from different agencies worked well together to benefit children and families: with staff referring and transferring children to other services safely. Staff understood how and when to obtain consent before sharing information with other agencies.

Staff cared for children and families with compassion, providing emotional support when necessary. They involved parents in decisions about their children.

The service planned and provided services in ways that met the needs of local people and their communities, using innovative ways to improve service provision. The service took account of children's individual needs and supported those in vulnerable circumstances.

The service had a vision for the future of service provision involving staff and parents. Managers had the skills and abilities to run the service, providing high quality sustainable care. It collected, analysed, managed and used information to support all its activities ensuring high standards of care. The staff were committed to improving the service and using innovation.

However, we also found the following issues that the service provider needs to improve:

Infection prevention and control measures were insufficient to protect children from harm. Staff did not adhere to good hand hygiene and the cleaning of toys was inconsistent. In some areas there was insufficient space to ensure privacy and confidentiality and at times staff had to carry equipment between clinics in order to undertake their work.

Lone working safety measures were inconsistent across the service and the service had insufficient staff to ensure children were safe and to provide the right care. However it was acknowledged a continuous programme of recruitment for health visitors was in place.

Performance figures for four of the five mandated health visitor contacts had not reached the service's own target of 95%.

Morale amongst health visitors was low in a number of areas across the county and they felt undervalued. Some staff feared retribution if they spoke out. The service risk register did not reflect the risks we identified during our inspection and the provider had no feedback mechanism for its health service provision.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for children, young people and families	Good	County Offices, Newland, Lincoln provided health visiting and children and young people nursing services to children, young people and families in the county of Lincolnshire. We found the following areas of good practice: Staff recognised safety incidents and reported them appropriately. They were investigated and staff learned from them. Staff knew how to keep children safe and were trained to recognise and report abuse appropriately. Children's records were kept securely, and individual risk assessments were clearly documented. Contingency plans for the interruption of services were in place. Services were based on national guidance with managers monitoring the delivery of the Healthy Child Programme and ensuring staff were competent to undertake their role. Staff from different agencies worked well together to benefit children and families: with staff referring and transferring children to other services safely. Staff understood how and when to obtain consent before sharing information with other agencies. Staff cared for children and families with compassion, providing emotional support when necessary. They involved parents in decisions about their children. The service planned and provided services in ways that met the needs of local people and their communities, using innovative ways to improve service provision. The service took account of children's individual needs and supported those in vulnerable circumstances. The service had a vision for the future of service provision involving staff and parents. Managers had the skills and abilities to run the service, providing high quality sustainable care. It collected, analysed, managed and used information to support all its activities ensuring high standards of care. The staff were committed to improving the service and using innovation. However, we also found the following issues that the service provider needs to improve:

Summary of findings

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Summary of findings

Contents

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County Offices, Newland, Lincoln

Services we looked at

Community health services for children, young people and families.

Summary of this inspection

Background to County Offices, Newland, Lincoln

The Health and Social Care Act 2012 gave responsibility for health protection to the secretary of State and health improvement to upper tier and unitary local authorities; Lincolnshire County Council is an upper tier authority. With the establishment of Public Health England (PHE) in April 2013, local authorities took on public health responsibilities with staff transferred in from local NHS providers and Directors of Public Health given statutory positions on new local health and well-being boards.

In October 2017 Lincolnshire County Council was registered as a provider of health care provision by the Care Quality Commission to provide the regulated activity, treatment of disease, disorder and injury from the location County Offices, Newland, Lincoln.

Lincolnshire County Council Children's Health Provision provide services to children, young people and families in the county of Lincolnshire, with a population of over 750,000 and an area covering 2,687 square miles. The area has a high level of deprivation particularly along the coastal strip from Skegness to Mablethorpe as well as areas of Boston, Lincoln and Gainsborough.

Service provision includes health visiting for 0-6 year olds (until the end of the reception school year) and input for specific needs from children's nurses for children from six and young people up to the age of 19 years. A single point of access service is available for parents and health care professionals through a single telephone line who may have general enquiries or concerns about the health of a child or young person.

The service also provides help and support to children and young people with a special educational need and disability (SEND) aged 0-25 years of age. The Care Quality Commission and Ofsted jointly undertook an inspection of SEND services in October 2018 which has been published.

Thirteen teams of health visitors and children's nurses are divided into four quadrants across the county: Lincoln and West Lindsey, North and South Kesteven, East Lindsey and Boston and South Holland.

The registered manager is Linda Dennett.

Our inspection team

The team that inspected the service comprised one lead inspector, three additional inspectors and two specialists in health visiting and safeguarding children.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive independent health inspection programme.

How we carried out this inspection

We visited 14 children's centres across the county of Lincolnshire to observe staff delivering care. We also visited the single point of access centre in Lincoln. We spoke with the Registered Manager of the service, the Nominated Individual for the provider, managers, health visitors, children and young people's nurses and parents of babies and young children. We reviewed data and information from the provider prior to and following the inspection.

Summary of this inspection

What people who use the service say

We spoke with three parents who had received support and we received consistently positive feedback about the care and support provided.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- Infection prevention and control processes were insufficient to protect children from harm. Staff did not always adhere to good hand hygiene and the cleaning of children's toys was inconsistent across the service.
- In some areas we found the service did not have sufficient space to ensure privacy and confidentiality could be maintained. At times staff had to carry equipment between clinics in order to undertake their work.
- The service had insufficient health visiting staff to ensure children were safe and to provide the right care. It is acknowledged a continuous programme of recruitment was in place.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave parents honest information and suitable support.
- Staff understood how to protect children and adults from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- In the majority of areas we visited the service had suitable premises and equipment and looked after them well.
- Staff kept detailed records of children's care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff completed and updated comprehensive risk assessments for each child. They kept clear records and asked for support when necessary.
- The service managed anticipated risks appropriately and continuity plans were in place..

Are services effective?

Good 

We rated effective as **good** because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Managers monitored the delivery of the Healthy Child Programme and constantly strived to achieve better outcomes for children and families.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held regular supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff from different agencies and in different roles worked together as a team to benefit and protect children. Health visitors, children and young people's nurses, social workers and police supported each other.
- Children were referred and transferred to other services safely.
- Staff understood how and when to obtain consent before sharing information with other services.

However:

- Performance figures for four of the five mandated health visitor contacts had not reached the service's own target of 95%.

Are services caring?

Good

We rated caring as **good** because

- Staff cared for children and their parents with compassion. Feedback from parents confirmed that staff treated them well and with kindness.
- Staff provided emotional support to children and their parents to minimise any distress.
- Staff involved children where possible, and their parents in decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as **good** because

- The service planned and provided services in a way that met the needs of local people and their communities. Staff used innovative ideas to improve service provision.
- The service took account of children's individual needs.
- The service supported children and their parents in vulnerable circumstances.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, sharing these with all staff.

Summary of this inspection

Are services well-led?

Good

We rated well-led as **good** because:

- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and parents.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.
- The service was committed to improving services for local communities by learning from when things went well and when they didn't, promoting training, research and innovation.

However:

- Morale amongst health visitors was low in a number of areas across the county and some staff felt unable to speak out for fear of retribution. Some health visitors did not feel valued.
- The service had systems for identifying risks although risks we identified on our inspection were not reflected on the risk register.
- Lone working safety measures were inconsistent across the service.
- Although the children's centres engaged well with parents who attended sessions there, the provider had no feedback mechanism for its health service provision.

Community health services for children, young people and families

Good

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are community health services for children, young people and families safe?

Requires improvement

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From the time of the service's registration with the Care Quality Commission to the inspection no never events had been reported.
- The CQC had received no notifications in relation to safety incidents for children, young people and families from the time of the service's registration with the Care Quality Commission to the inspection.
- There were four serious incidents requiring investigation reported from the time of the service's registration with the Care Quality Commission to the inspection.
- All serious incidents were referred to the Serious Incident Review Group and/or the Federated Safeguarding Team as required which was overseen by the Clinical Quality Board
- All staff we spoke with could describe the incident reporting process and were confident in reporting. The lead nurse reviewed incident themes and presented findings at the monthly clinical quality group meetings. The meetings were attended by the four locality managers for the service and a practice supervisor. Types of incidents discussed included complaints, new policies and procedures and the risk register. At the meetings staff also discussed innovative ideas. A recent example of this was a trial for 'opt in' appointments for parents.
- Although no incident dashboard was available at the time of our inspection we were informed one was being developed. A policy was in place for clinical incident reporting. We received data from the service that showed 347 incidents had been recorded in the previous twelve months across the nine teams and business support services. 128 of those were relating to appointment issues. We reviewed an electronic report where no harm had occurred to the child concerned. The investigation was thorough, lessons had been learned and processes updated as a result to reduce the likelihood of it happening again.
- Staff told us they received feedback from incidents or issues that had arisen. We reviewed meeting minutes from quadrant meetings and saw any lessons learned were shared with the team. as part of the standard agenda items. In one meeting an information breach was discussed, how it occurred and how it could be prevented from occurring again.
- Because of language barriers in a certain area, non-English speaking families had been highlighted to attend appointments at specific clinics to ensure translation services were available to support them and introduce the families to children's activities which they could take advantage of.

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- The lead nurse analysed all incidents to identify themes and trends. Incidents were discussed at Serious Incident Review Group meetings and the Clinical Quality Board. Incidents were sent to the most appropriate person to investigate.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires all providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with about duty of candour understood it and the importance of being open and honest with patients when mistakes were made. There had been no duty of candour incidents since the registration of the provider.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- Staff managed all safeguarding issues with the safety of children at the forefront. Staff we spoke with at all levels, including business support staff in children's centres, were aware of what constituted safeguarding, not just for children but for parents as well.
- During the 11 months from April 2018 to February 2019, 71 safeguarding referrals had been made from heath visitors and children and young people's nurses.
- All qualified staff were trained to safeguarding level 3 and practice supervisors to level 4 with the National Society for the Prevention of Cruelty to Children. Training courses relating to all aspects of safeguarding were accessed through the Lincolnshire Safeguarding Children's Board website and included awareness of child abuse and neglect, domestic abuse and violence, child trafficking and female genital mutilation (FGM). FGM is the ritual cutting or removal of some or all of the external female genitalia.
- A specific safeguarding template had been developed that supported identification of safeguarding risk. This promoted effective and timely information sharing and joint working to meet needs.
- The number of 0-5 year olds in Lincolnshire at the time of our inspection was 43,792. The number of children under child protection was 173 and the number of children in need was 428. A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of support services; It can also be a child who is disabled. Child protection is the protection of children from violence, exploitation, abuse and neglect. Child protection systems are a set of services designed to protect children and young people and to encourage family stability.
- All community children health staff had access to the social care electronic recording system. This enabled staff to see social worker records for parents and children, enabling immediate information sharing of concerns and alerts. Staff stated this was very helpful when assessing what intervention was needed for families.
- Health visitors attended monthly safeguarding meetings at their named GP practices to discuss new or on-going issues.
- A health visitor informed us the service received a notification form from the emergency department if a child had attended a hospital for an injury. The health visitor for the child would then undertake a home visit to discuss the injury to determine whether it could be as a result of a non-accidental incident.
- The service attended a multiagency risk assessment conference (MARAC) fortnightly where managers discussed high risk domestic abuse cases.
- In the children's centres we visited, where health visitors undertook their clinics, we saw posters in place to alert parents to domestic abuse, child trafficking and female genital mutilation (FGM) and how they could obtain help. These were available in languages which reflected the local population.
- Practice supervisors in each locality team provided safeguarding supervision for all qualified staff at monthly intervals to give the practitioners the opportunity to discuss cases.
- The lead safeguarding nurse for the service provided clinical group supervision for staff where lessons learned were discussed. They were also available for staff at any time for advice and support. Staff felt well supported by the lead safeguarding nurse.

Community health services for children, young people and families

Good

- Health visitors received any identified safeguarding concerns from community midwives when mothers-to-be booked in with the midwifery service.
- Icons were used on the electronic record system to show where there were identified safeguarding concerns for a child. Health visitors set a reminder on the front page of the case notes on the system to remind them of any child protection concerns or other concerning issues and to remind them of the next meeting date.
- Health visitors were copied into any child safeguarding referrals made to the provider's children's safeguarding team; they then undertook monthly visits with the family or more frequently if required. Health visitors also undertook weekly visits for identified child protection cases and worked with social workers to carry out joint visits.
- Staff in the single point of access team based in Lincoln attended safeguarding training provided by their dedicated training and compliance officer; their training was tailored to their role. Staff did not have access to suitable prompts when taking calls from parents in vulnerable family settings. However they did have access to knowledgeable managers at all times.
- A safeguarding supervision audit had been agreed by the clinical quality group from a supervisee's perspective. This was due to commence in May 2019.
- Staff were aware of learning from Serious Case Reviews (SCRs). Actions were in place to reflect the learning. For example, all Lincolnshire Safeguarding Children Board (LSCB) policies were accessible to staff and a five year LSCB Safeguarding training programme had been recently re-launched and included in the service's safeguarding training strategy. In addition, the service provided assurances to LSCB on the use and understanding of the professional resolution and escalation procedure.
- A presentation had been put together for locality managers to cascade to their teams reflecting the lessons learned.

Environment and equipment

The premises used by the service were not always suitable for its use because of the lack of space and not all clinics were equipped with suitable equipment.

- Health visitor clinics were held in the premises of Lincolnshire County Council Children's Centres. A total of 70 clinics were provided this service. As well as health visitor clinics, maternity services were provided by a local NHS trust and commissioned services such as early play groups were also available for different age groups in the clinics and families could attend these if they wished. This meant parents could access the premises for both children's health and social benefits. All the children's centres we visited were visibly clean and toilets were available for parents, children and staff.
- Of the 15 clinics we visited we saw the estate varied, in that some premises were very new and spacious while in others space was very limited. Some of the older children's centres, such as St Christopher's in Boston, lacked the space to provide suitable numbers of clinics and in the same facility we found two clinic rooms did not have independent access; staff and parents were required to walk through one clinic to the second. We were present at St Christopher's in one clinic room when staff and parent had to pass through it to access the second. This may prevent a parent from having a sensitive discussion with their health visitor because they were disturbed.
- Clinic rooms were clean and tidy and equipped with suitable toys. Appropriate equipment such as weighing scales, tape measures for assessing height and head circumference were generally available. Weighing scales had been tested within servicing timescales and were calibrated annually. Not all clinics were equipped with suitable equipment and we saw some health visitors bringing a set of scales with them in order to weigh infants. It is acknowledged that health visitors were required to take equipment out with them to undertake home visits such as a measuring mat, blue paper roll, disinfectant wipes, hand gel and disposable gloves.
- Following our inspection the provider informed us the weighing scales health visitors and children and young peoples nurses used and transported were designed to be mobile, in that they were lightweight and met all Health and Safety manual lifting and handling standards.
- Staff had recently been equipped with new laptops and smart phones which had helped with working remotely as they could update their systems. However, accessing phone and broadband signals in very rural areas was challenging.

- Staff did not have lone working devices at the time of our inspection although these were being planned by the service. The new devices would record the staff member's voice and would trigger an immediate response if there were any issues.
- Current lone working safety measures were inconsistent across the county. Two health visitors told us they would ensure their practice supervisors knew when they arrived at a property and when leaving, if they thought it would be challenging. Another health visitor told us they would visit in twos if there was a known risk. A third health visitor told us that they would ensure their manager knew where they were if they worked late and would phone them when they finished.
- Fire wardens were in place at each centre and on two occasions we were shown where the fire exits were when we entered the buildings.

Quality of records

Staff kept detailed records of children's care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

- Children and young people's records including care plans were held on an electronic records system which could be accessed and shared with the majority of GP practices across Lincolnshire.
- Staff used a smartcard as well as passwords to access the electronic system on their laptops which provided an additional security measure.
- We reviewed five care records on the electronic system. Records included individualised care plans, risk assessments, action plans and relevant pathways. They were clearly set out, legible and comprehensive. They followed a similar pattern to the social services system of record keeping in the county. This meant that information on what staff were worried about, what was working well and what actions needed to happen were all evident for each child.
- There had been a recent quality of record keeping audit in December 2018 which was in the process of being reported on.
- All staff were required to complete data protection and information security training as part of their annual mandatory training.

Cleanliness, infection control and hygiene

The service did not always control infection risk consistently well. Staff did not always follow 'bare below the elbows' policy or keep toys clean to prevent the spread of infection.

- All clinic rooms we visited were visibly clean and tidy. Generally staff washed their hands and/or used hand gel between children's health review appointments. However, not all health visitors in the clinics we visited adhered to the arms bare below the elbows guidance, in line with national good hygiene practice. We observed some health visitors did not always wash their hands or clean toys between or at the end of reviews. When we discussed the infection control of toys, opinions were mixed about how toys were kept clean. Some staff told us they washed the soft toys in a washing machine while others told us they sprayed antibacterial spray on them.
- In one clinic we visited, the health visitor could not tell us when or how toys were cleaned and were not aware of the cleaning regimes.
- We received from the provider a copy of the 'Guideline for hand washing and the use of hand santiser for the children's health workforce'. The document was dated 23 February 2018 and stated clearly how and when to wash hands with soap or hand sanitising gel.The check sheet used for rooms before and after clinics did not include a check for ensuring toys were cleaned, it stated toys and equipment were clean and left in working order. One children's centre had added that toys should be cleaned in pen at the top of the room check list but the check list itself had not been altered. We raised this issue with senior managers who told us they would send us the updated policy on infection control as they realised this was an issue that needed addressing.
- Following our inspection we received three procedures/ checklists for infection control. The hygiene and infectious disease procedures for children's centres had been written in November 2010, before the service TUPED from the previous provider of services, with a review date of November 2011. We were not sent any further updated version of the procedures. The document, referencing the Health Protection Agency was comprehensive and included when and how toys should be cleaned and with what. The room checklist did not reflect how often toys should be cleaned. The outdoor checklist for centres that had access to an outdoor play area included checks relating to the

clearing of any rubbish, protection of children from any herbicides/pesticides used in the garden area and to ensure 'toys were in working order and safe'. It did not reflect how often toys should be cleaned.

- Following our visit we were sent cleaning regimes for each area in each child's centre. The regimes stated how often cleaning should be undertaken, i.e., daily, weekly, monthly or annually. Toys were included on a daily basis. When we visited children's centres and asked about the cleaning of toys staff could not show us any completed forms. We were therefore not assured that toys were being cleaned frequently in line with the hygiene and infectious disease procedures for children's centres processes for the 'keeping of toys and equipment clean and safe' and the 'care of play equipment'.
- In addition, the provider informed us that work by the children centre lead and Public Health had already commenced (January 2019) on reviewing the Infection Prevention and Control policies and process for children centres and an annual audit programme was already in development.'
- We observed good hand hygiene from staff within family homes and staff used blue paper roll to line changing mats and baby scales between each use.
- Managers and staff informed us there had been a recent handwashing audit but the results were not yet available. However, in some areas we were informed this had been undertaken without a sink, soap or any water.
- A clinical waste provider collected waste on a weekly basis which included soiled nappies. In one clinic we observed nappies had not been placed in nappy bags in one toilet before being placed in the bin provided with no nappy bags available for parents to use. As a result the bin was half full with offensive waste. We brought this to the attention of the centre staff on the Monday of our inspection. They informed us the bin had been emptied the previous Friday.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Depending on their job roles, staff were required to complete a range of mandatory training most of which was completed on-line via a specific website. Some of the courses were undertaken on a once-only basis while others were completed either annually or every two to five years. The course list was comprehensive and included fire safety, equality and diversity, emergency first aid, appraisal for appraisees and basic paediatric life support.
- Compliance rates for mandatory training were 96% across the nine teams, exceeding the provider's own 95% target.
- Staff informed us they were reminded of mandatory training via an email message and this would continue until they had completed it.
- Practice supervisors and locality managers discussed mandatory training individually with staff during supervision sessions.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child when appropriate. They kept clear records and asked for support when necessary.

- The single point of access (SPA) centre staff were responsible for ensuring any child moving into the county was allocated to the appropriate team depending on where they lived. Likewise, the SPA team ensured the receiving children's service was made aware of where a child was moving to if this was out of the county. This was especially important if a child was at risk in any way.
- Health visitors reviewed all GP, out of hours, and A&E attendances to monitor the children on their caseload.
- Practice supervisors (health visitor's immediate line managers) informed us they were constantly reviewing workloads of individual health visitors ensuring an equitable workload across teams so no one in the team was dealing with more complex cases requiring more input than any other. This ensured vulnerable children were prioritised and staff had the ability to give them the time in order to reduce risk.
- A full risk assessment was undertaken at the first mandated pre-birth visit at approximately 26 weeks. This included any possible domestic abuse, the physical and mental health of the pregnant woman and the general physical environment. The service did not have access to any mental health records for the pregnant woman.
- Single assessment meetings for children requiring protection, child in need or 'team around the child'

(TAC) support took place in Grantham. They were attended by a multidisciplinary team, which included police, health visitors and practice supervisors for both health and social care services in Lincolnshire. Each case was discussed in detail to determine the main issues, assess the risk and agree appropriate action to manage the risk. Staff discussed children who were at risk during their team meetings.

- Some of the staff we spoke with in one team felt they had been informed too late of the 'child in need' meetings and therefore were not always able to attend because of other diary commitments. As a result, a member of the team was collating a month's data of this information and would, depending upon the results, take this forward with senior managers to discuss a way to resolve the problem.
- School nurses were not being utilised in Lincolnshire but any child requiring support either at school or at home from the children's health team were supported by a designated family health worker (FHW) who was a trained nursery nurse. The FHWs worked under direction of the health visitors. We observed this when a health visitor offered written information as well as support to a family from a FHW where a young child was giving cause for concern. The parent was very grateful for the input from the FHW although the health visitor informed the parent the support could take up to twelve weeks to put in place. The health visitor told us this was an over estimate of the time it would take.
- Child risks and issues were clearly documented in their electronic records. For example, we saw risk details in one child's records with a plan of what to do if this occurred.
- Health visitors told us that if they felt they were not able to meet the needs of children they would escalate this to their practice supervisor for discussion.
- Health visitors had access to their own and other colleague's electronic diaries. This enabled them, when necessary, to check each other's appointments on the system and provide cover for any urgent issues or if their colleagues were off sick or on annual leave.
- Health visitors undertook mandatory development reviews with babies and young children to assess risk and keep them safe. During the reviews we observed staff ask a range of questions to parents to assess the well-being of both the child and the parent. Questions about feeding, sleeping and support at home were included as well as a discussion about vaccinations and vitamins.
- Staff documented the outcomes of development reviews both on the service's electronic system as well as in the child's personal health record, or 'red book' which is usually brought to the clinic by parents. The red book is a comprehensive record of a child's weight and height, vaccinations and other important information from birth onwards. Parents can add information to the red book themselves such as illnesses or accidents their baby has,or any medicines they take.
- In order to ensure children were safe, if parents did not attend a booked appointment with a health visitor, the single point of access team sent a letter to the parent offering to re-book the appointment. Some health visitors, although not all, called parents to see why they did not attend the appointment.
- All clinic staff were trained in basic paediatric life support but if children or adults at any clinic became ill the emergency services were called.

Staffing levels and caseload

The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The service employed approximately 111 whole time equivalent (WTE) health visitors and 14.8 WTE children and young people nurses (CYPN) who were in post as of 1 March 2019. The service was only funded for 12 WTE CYPNs. CYPNs worked across the county but were based in localities.
- There had been 12 health visitors, one student health visitor and two CYPNs as substantive staff who left in the year ending 01 March 2019. Vacancy rates for health visitors at the time of our inspection was 11.3%. The provider had a rolling recruitment programme in place.
- The service's capacity to deliver the full Healthy Child Programme (HCP) had been affected as not all families had received the five key developmental stage reviews. The service had realised actions were needed and family health workers (FHWs) had received additional training to undertake the 2-2.5 year old development review. As a result of this the percentage of children having received this review had risen from 36% in

October 2018 to 76.7% in February 2019. The service's own target was 95% but the service was confident this would be achieved quickly and was on an upward trajectory. Following our inspection the provider informed us the HCP had also been impacted due to a deficit in available clinical spaces which had been rectified.

- Some of the health visitors we spoke with told us they had been told by senior managers they did not have caseloads but were named workers for children. They told us they were not happy about it and had discussed it in supervision although they had not received an acceptable response.
- There were 13 health visiting teams across the county of Lincolnshire. We spoke with health visitors about their caseloads and found they varied between 250 and over 400. The Institute of Health Visiting recommends a maximum of one health visitor to 250 children to deliver a safe service.
- We spoke with the Registered Manager of the service who informed us they did not use the term 'caseloads' but that every child had a named health visitor for continuity of care. Health Visitors worked corporately and on an 'active caseload ' basis and took account of part-time staff.
- Team caseloads were defined by population numbers and 'deprivation' that took into account the factors that were most likely to mean that health visitors would be providing higher-levels of intervention for some families. The resource allocation tool used provided a 'scientific' method of allocating health visitors to teams. Senior managers informed us this would support the service and ensure that teams continued to be appropriately and safely resourced.
- Each team had a nominated caseload and cases were allocated via a 'Matrix allocation' to ensure that workloads and safeguarding caseloads were distributed safely each week. Other commitments such as training and supervision were also protected as staff were only allocated work that could safely be delivered in the time available that week.
- Following on from our inspection the provider informed us that the service also employed a skill-mix workforce of family Health Workers (qualified Nursery Nurses) who delivered individual care programmes, two year development reviews, supported community based Health Visiting programmes including parenting support, antenatal education and breastfeeding support groups. Their whole-time equivalent (WTE) was factored into the overall establishment and team caseloads although the Health Visitor remained the named caseload holder.
- We were also informed the corporate caseload model ensured the service worked within the guidelines of the Community Practitioner and Health Visitor Association (CPHVA 2009) which stated that 400 should be a maximum caseload and 250 was the ideal caseload number for any health visitor.– if the provider averaged out the FTE Health visiting workforce (inc Family Health Workers and the contribution of practice supervisors, caseloads amounted to 350 on average. However, in reality the average caseload for some teams working in high deprivation areas were much smaller than this and was reflected in the higher number of Health Visitors allocated to those teams. In the context of matrix management and activity based workloads the provider considered that this was safe.
- If a health visitor required the support of a family health worker to assist families, they had to make a referral for that intervention. The time frame for receipt of this support was three months. However we were informed this generally occurred sooner.
- Children and young people nurses provided support for children from 6-19 years of age who required it on an individual basis only. This could include visits to their homes, support in clinics or visits to their schools. Support included continence, enuresis (involuntary urination, especially at night), healthy weight and complex health needs. They were also able to recommend suitable continence products if these were required. At the time of our inspection and until a Lincolnshire wide continence pathway/service, which met the needs of all children and young people was commissioned by the Clinical Commissioning Groups, the service was delivering support to young people beyond its remit. The service was a targeted service implemented following extensive consultation on the health needs of Lincolnshire school aged children and young people. In addition CYPNs undertook a health needs assessment for relevant safeguarding cases or referrals and supported safeguarding and individual needs cases where a health need was identified
- Children and young people nurses were able to deliver education to schools, if requested, for issues such as the

Community health services for children, young people and families

Good

use of equipment for asthma sufferers. They did not however attend schools on a regular basis unless it was to see and discuss individual children to meet their needs.

- The service had used qualified relief health visitors when required to ensure essential services were maintained. Figures supplied by the service showed between October and December 2018, 94.3 days of relief workers had been used.

Managing anticipated risks

Although records were kept of potentially challenging situations, staff were not always protected well when lone or late visiting.

- The service kept a record of potentially challenging or violent individuals who posed a threat to employees or others. This information was recorded in the child's electronic record. This was shared amongst the staff that needed to know. Staff received training in conflict resolution and visited in pairs when a risk had been highlighted.
- There did not appear to be any formal process to ensure staff were safe following lone or late visits to families where staff could be vulnerable. If staff did not arrive for a home visit or return after one the police had to be alerted.
- Following our inspection the provider informed us that a lone working policy was in place and has been reviewed as part of the transfer of the service from a local NHS community trust. The policy recognisesd there were different working patterns and risks and the day to day responsibility for this was the local line managers who undertook risk assessments and had measures in place that were appropiate for the circumstance and environment. Therefore specific arrangements varied across teams.
- In addition, staff providing the service did not undertake late visits as routine, and where they did they were expected to inform their line manager. Core working hours were 9-5pm with the exception of ante-natal education programmes and some Saturday morning clinics. Both of those were held in children centres and staff did not work alone. Teams had local 'buddy' systems in place overseen by their practice supervisors.

Major incident awareness and training

Plans were in place to ensure services could still respond in times of a major challenge.

- Comprehensive continuity plans were in place for both children's health services and the single point of access (SPA) team. They covered loss of premises, information technology, people as a result of a pandemic and loss of utilities. There was a clear action plan for an initial response with a flow chart. It had been approved in August 2018 and reviewed in November 2018.

Are community health services for children, young people and families effective?

(for example, treatment is effective)

Good

Evidence based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- Policies and procedures were in line with the National Institute for Health and Care Excellence (NICE) and national guidance.
- The service followed evidenced based programmes, for example the Healthy Child Programme (HCP).
- Health visitors used Ages and Stages Questionnaires (ASQs) as part of their assessment of children. This is an evidence-based tool completed by parents prior to development reviews to identify a child's progress, readiness for school and to identify support required by parents in areas of need.
- Staff told us they had access to policies and these were stored on the organisation's intranet. Some staff said they had received a lot of new policies in the weeks prior to our inspection. We reviewed several polices, for example jaundice in neonates, new-born bloodspot screening and infant feeding policy. Review dates were within timescales.
- The service provided breast-feeding support to new mothers, including support and advice. During our inspection, we observed a breastfeeding peer support group taking place in the room next door to the baby clinic.

Technology and telemedicine

Community health services for children, young people and families

Good

Staff had access to technology available to both social workers and GPs

- All community child health staff had access to the electronic system used by the social work teams as well as the system used by the majority of GPs in the county. At the time of our inspection the electronic system worked in four separate quadrants to reflect the way the service was delivered. However work was in progress to enable all quadrants to become one so access would be simplified.

Nutrition and hydration

Staff gave breast feeding a high priority and worked with speech and language therapists to support children with complex needs.

- Health visitors provided support and information for children with complex feeding needs and worked with the speech and language therapy service. Health visitors were able to refer to the service when necessary.
- Health visitors told us breast feeding had a high priority. The service had a number of 'champions' across the county. A breast feeding champion was one role that had been developed. The support from the champions had been welcomed by new mothers.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

If any learning needs were identified by a health visitor, the child could be referred directly to the early years team for progression on their pathway through an assessment process and onward support.

- The health visiting service delivered the Healthy Child Programme (HCP). The HCP focuses on a universal preventative service, providing families with a programme of screening, health and development reviews, supplemented by advice around health, wellbeing and parenting. The immunisation programme for children and young people was provided by a local NHS provider.
- At the time of our inspection health visitors had been struggling to undertake all the five mandated development reviews because of staff shortages. However, this had improved with the help of additional training delivered to health care workers who were able to undertake the 2-2.5 year reviews.
- The five mandated contacts by health visitors for all children were:-
  - Antenatal (approx. 26 weeks of pregnancy)

    Primary birth (within 14 days)

    Six to eight weeks

    Twelve month

    Two to two and half years
- Although the service had not always attained its own target of 95%, figures showed the six to eight week and twelve month reviews for February 2019 were 89.1% and 84.9% respectively which were in excess of the national figures of 85.4% and 76.8%. The 2-2.5 year review figure of 76.4% was slightly below the national figure of 78.2%.
- Registered Manager/Lead Nurse and locality managers for each quadrant had good oversight of HCP attainment figures and received performance reports on a monthly basis not only for their quadrant but also comparison figures for all four quadrants. Locality managers told us it motivated them to do better.
- The National Child Measurement Programme (NCMP) is a nationally mandated public health programme. It provides the data for the child excess weight indicators in the Public Health Outcomes Framework, and is part of the government's approach to tackling child obesity. The service achieved a high overall participation rate of 96.4% % in the NCMP, which was better than the England average of 94.7%

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

- Staff informed us competencies were part of the discussions they held with their line managers during supervision sessions which took place every six weeks. If staff felt they needed additional training this was arranged for them.
- All staff we spoke with stated the opportunity for training had improved greatly over the previous 18 months.

Community health services for children, young people and families

Good

- Leadership training was available for practice supervisors and locality managers. This ensured staff were supported in career progression opportunities and aided the employer in succession planning.
- A locality manager we spoke with informed us they were undertaking an eight month programme of managing change. This included modules relating to change management, motivating others and strategic thinking and planning. It also included a 360 degree appraisal. A 360 degree appraisal is a type of employee performance review in which subordinates, co-workers, and managers all anonymously rate the employee. This information is then incorporated into that person's performance review.
- The service was training nine student health visitors, all of whom had been offered employment opportunities once they completed their training in September 2019.
- The service employed clinical practice educators who supported individual practitioners in their learning and offered the opportunity for one to one sessions should they require it. Staff were able to attend both clinical and professional conferences.
- Line managers encouraged staff to broaden their knowledge and experience.
- Staff did not have to use annual leave or take unpaid leave to attend training sessions. Their attendance during working hours was agreed with their line managers.
- An induction programme was in place for newly appointed staff that joined the service.
- Staff told us they received supervision every three months, which was documented by their team leaders.
- The health visitor service had specialist champion roles which gave them the opportunity to develop their interests and for which they received additional training. This included breastfeeding, maternal mental health, accident prevention, healthy growth and school readiness. These roles helped further support families and children.
- The mental health champions were able to undertake formalised 'listening' visits with parents and had also received cognitive behavioural therapy training to support parents with mental health issues.
- Health visitors and children and young people's nurses were able to access a variety of services that were either commissioned by the provider or provided by other organisations in order to further support children and young people when required. This included mental health services, and sexual health.
- Appraisals for staff were undertaken annually with a six monthly review. The process included the setting of service and personal objectives. Compliance rates were 100%

Multi-disciplinary working and coordinated care pathways

Staff worked together with social workers, doctors, midwives and the police as a team to benefit children and young people.

- Services for children and young people worked together and with external agencies to assess, plan and co-ordinate the delivery of care.
- Staff described positive links with the local multi-agency risk assessment conference. All information from the meetings was uploaded onto the electronic system used by the service: we were therefore assured information was available to all who needed to see it. Health visitors reported good relationships with the majority of GPs across the county.
- The service had a memorandum of understanding between Lincolnshire GP Practices and the 0-19 Link Practitioner, Children's Health Service which further strengthened the channels of communication. The provider's document Standard Operational Guidance, evidenced processes were clearly set out how link practitioners should work with GP's to ensure children received safe and effective care.
- In order to promote and improve the working between social services and health, health visitors were based in social services offices across the county. Health workers told us the communication between the two organisations was much better and had become quicker with strong links being developed. We witnessed this during our inspection when a quick response from all involved agencies was required to protect a young child who was in vulnerable circumstances.
- A health visitor was 'on duty' every day for each team. They were available for the members of the single point of access (SPA) team to contact if they received calls

from parents or other health care professionals. We were told the process was very quick. Prior to the SPA it could take a number of days before health visitors called parents back.
- The service worked with the education department within the county council who identified poor school attendance and with the Child and Adolescence Mental Health Service (CAMHS).
- They also signposted parents and children to other services, for example an organisation that **provided emotional wellbeing support to children and young people up to 19 years old (25 if special educational needs/disability or leaving care.**
- Health visitors met monthly with the community midwife for their area at local GP services.
- Health visitors with a mental health champion role worked with the perinatal mental health service to coordinate support for parents.
- Health visitors told us that sometimes they did not know if a woman was still pregnant when they were arranging for their antenatal visit. This could cause distress for the woman concerned and embarrassment for the health visitor. This was due to an issue concerning a third party provider. Following our inspection the provider informed us they had recognised the need for improved communication pathways and had introduced an 'Antenatal Pathway Lead' role. One of the main responsibilities of the postholder, a qualified and registered midwife, was to work with partners and stakeholders to improve communication and pathways for pregnant women.

Referral, transfer, discharge and transition

Parents and staff were able to access systems to support them in ensuring children referred in or out of the service or transitioning between services were dealt with appropriately.

- Health visitors told us they worked closely with the children and young people nurses team to discuss any vulnerable pre-school-age or reception age children and ensured they shared important information were they were transferred from the health visiting team to the children and young people nurse team.
- The children and young people nurse team were involved in meetings to discuss the transition of young people with special needs from child to adult services.
- People could contact the single point of access (SPA) team through one telephone number. The team generally answered the call within six or seven seconds (the target was twenty seconds) so parents or health care professionals did not have to wait to arrange appointments with a health visitor. The SPA team could book appointments with a health visitor so callers did not have to wait to be transferred.
- Children who moved in or out of Lincolnshire were referred to the appropriate children's team as quickly as possible to ensure their care and follow-up was seamless.

Access to information

Staff always had access to up-to-date, accurate and comprehensive information on children's care and treatment.

- All contacts with children throughout the service were recorded on the electronic records system. This meant information could be shared across the services and teams.
- The service was able to view the social services electronic system but was not able to add or alter any information.
- The majority of GPs across Lincolnshire used the same electronic system as the children's service. Health visitors told us that communication with GPs was easy if the practices used the same system. If they needed to make contact with a GP urgently that was not on the same system, it required telephone calls to be made which could cause delays.
- Information for parents was widely available to parents attending the health visitors and children and young people's nurses in the Children Centres. In certain areas of the county posters and leaflets were available in different languages.

Consent

Staff understood how and when to ask for consent from a parent. Staff also understood the Fraser guidelines and Gillick competency.

- Consent by parents for sharing information with other services such as GP's, was generally made at the first home visit by a health visitor, i.e. within 14 days of a baby's birth. Staff discussed any plan of care with the parents and made sure they were in agreement with the plan.

Community health services for children, young people and families

Good

- Health visitors understood the Fraser guidelines and Gillick competency. Fraser guidelines and Gillick competency must be considered when offering treatment to children less than 16 years old, to decide whether a child is mature enough to make decisions about their own care.

Are community health services for children, young people and families caring?

Good

Compassionate care

Staff cared for children and their parents with compassion.

- We spoke with 14 families at clinics and during home visits with health visitors. They all had babies and young children who were receiving care from this service and all gave very positive feedback about their care and treatment. We were not able to speak with older children as we did not undertake visits with children and young people nurses.
- We observed staff communicating with patients and their families in a respectful and considerate manner. Staff took time to explain things clearly and took the time to answer questions.
- One family explained how they were having problems with one of their children. The health visitor listened attentively and indicated they understood the anxiety this was creating. They gave some tips and advice to help with the immediate concern and then asked if they would like a referral to the health support worker for more in-depth support, which they accepted. The family were very grateful and told us they were going to put the tips and advice into action.
- A parent told us their health visitor was 'amazing and ever so friendly'. They said they had been particularly good with an older sibling and kept them occupied during checks on their baby.

Understanding and involvement of patients and those close to them

Staff involved parents and children where this was appropriate, in decisions about their care and treatment.

- Staff told us they always put the care and welfare of children and families at the heart of everything they did. The children and young people's nurses we spoke with told us they recognised that listening to what the child said with regard to their care and treatment was vitally important in the work they undertook.
- During observations at home visits by health visitors, we saw they were considerate to the situation of parents. During their checks of children they spoke with the parents and when present, to other family members, to keep them informed of what they were doing and why. Following a review the health visitors fed back to parents the outcome of their checks.
- During clinic visits staff explained to parents the outcome of the reviews they undertook on their babies and young children. This included for example where the child was on their growth chart and if the result was within the expected range for their age.

Emotional support

Staff provided emotional support to parents and children to minimise their distress.

- Health visitors told us they encouraged families to attend clinics so they could develop a rapport with them and offer any emotional support as and when it was required.
- Staff told us emotional support for first time mothers who were breastfeeding was particularly important. The six to eight week review was the time when additional emotional support was sometimes required as some mothers found it difficult to maintain the breast feeding regime as it could be both physically and emotionally tiring.
- Listening to families was seen as an important part of the health visitors' role. They tried to ensure parents felt able to talk about anything that was worrying them so they did not feel inadequate or silly for asking questions.
- Because health visitors held clinics which were generally within rooms at local children's centres, parents were able to access other activities for their children that helped to emotionally support them. For example talking and socialising with parents in similar situations as themselves. Health visitors suggested these activates as a way of providing emotional support.

Community health services for children, young people and families

Good

- During one home visit we observed a health visitor being attentive to what was being said and really listening to the needs of a mother. The health visitor recommended attending mum and baby groups for peer support. The health visitor stressed they were available and to contact them at any time should they need any advice. The health visitor had made extra visits to ensure the family were supported and the wellbeing of the mother and child were monitored closely. Mental stimulation of the child had been encouraged and the health visitor had taken books from the children's centre to help with this. They were responsive to the family's needs of how to arrange further visits and used text messaging to inform the family of when they would next visit. This has previously worked well for them.

Are community health services for children, young people and families responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services which meet people's needs

The service planned and provided services in a way that met the needs of local people.

- The County Council's children's health provision worked closely with all other agencies to ensure they were meeting the needs of the local population. This included local mental health, community and acute NHS trusts.
- The provider of this service was also the commissioner of it. Performance data was discussed regularly through the governance processes and the service reviewed, to ensure the needs of children and young people across the county were being met appropriately.
- The service had extended clinic times across the county quickly, as a response to mandatory review performance targets not being met at the end of 2018 and therefore children not being reviewed in a timely manner. For example additional one year review clinics on Saturday mornings had been put in place, which meant clinics were easier to access for parents who worked. Staff had also been flexible in their working hours to enable the clinics to be staffed appropriately and performance data had improved significantly. This had also meant health visitors could concentrate on undertaking antenatal home visits to women during the week.
- We saw in one children's centre staff preparing for an evening session to teach prospective parents about skills they needed. The course lasted over a period of four weeks with midwives and health visitors delivering the information. Comments had previously been made about the timing of the sessions and the inability for some people to attend. This had been addressed and the courses were rotated to deliver them across the day and evening so that partners could attend as well as mum's to be who worked.
- Staff had adapted the format of support groups to make improvements to benefit parents and children. For example at one breastfeeding support group, staff had changed the format to a group session rather than one-to-one. Feedback from women using the service said this was an improvement as women could also support each other.
- Boston and South Holland locality had secured £75000 of government funding to employ someone to produce a training package to educate parents about health services in the area. The locality had a high population of people from other countries and it was hoped the training package would improve language and numeracy skills for the population it reached.
- Following a local needs assessment, a second bid had been put together to fund the building of raised vegetable beds so that families could cook with locally grown produce.
- Because of high deprivation in certain areas across Lincolnshire, staff were able to hand out food vouchers to families in need when this was required.
- All the children's centres we visited offered a variety of additional services for parents that health visitors could signpost them to. This included sharing of books and toys that were returned when parents had used them for their children. In addition each centre offered a variety of good quality young children's clothing which were free. Staff told us that this service was well used.

Equality and diversity

Staff treated children and parents of all nationalities and protected characteristics equally.

Community health services for children, young people and families

Good

- The provider had equality objectives documented in the Council Business Plan 2018 – 2020. The objectives were comprehensive and included such issues as eliminating discrimination, harassment and victimisation and fostering good relations between people who share a relevant protected characteristic and people who do not share it.
- Interpreter services were available for patients whose first language was not English which in some areas of the county was required regularly. Staff told us there were no problems accessing this service. Leaflets were available in many languages including Russian and Mandarin.
- Health visitors had a very good understanding of the diversity and cultures in populations across the area in which they worked. Some localities had a high proportion of Eastern European families. Staff we spoke with ensured they were included in any activities they provided.
- All of the locations we visited had disabled access.
- The clinics we observed were bright, tidy and welcoming. Notice boards on the walls displayed a large amount of useful information for parents, some in different languages.
- Staff were required to complete equality and diversity training as part of their mandatory training. Compliance rates were 96%.

Meeting the needs of people in vulnerable circumstances

The service had planned services and trained staff to ensure people in vulnerable circumstances were supported.

- Health visitors supported children and families in vulnerable circumstances through the sign posting and referral of children and involvement with any one of a number of early help providers in Lincolnshire, the majority of which were commissioned by the provider, Lincolnshire County Council; these included teenage pregnancy. Staff did their best to ensure those most in need of support were engaged in the most appropriate services. We were able to see how staff utilised the most appropriate service quickly and effectively to meet children and parent's needs.
- Staff told us the Boston health visiting team had a dedicated neonatal link health visitor; they had a background as an experienced neonatal nurse. The new role had emerged following a discussion at a perinatal mental health conference where it was found that families with babies in the neonatal unit failed to receive early community support. The dedicated health visitor visited the neonatal unit at the local hospital once or twice a month to meet with families and offer support prior to their baby being discharged. Staff told us this prevented families from feeling isolated.
- One health visitor had received additional training to support women with young children who were fleeing from an abusive relationship and who were being accommodated in a local refuge.
- In some areas of the county health visitors worked routinely with families of ethnic minority groups to identify their needs. Children centre staff made great efforts to ensure families were included in the activities.
- The service had worked closely with a company providing free on line information for parents to be. On successful completion of a short course parents were provided with a free box to use as a bassinette for those not having a small crib or basket for their new baby to sleep in. This initiative had just started when we inspected the service.

Access to the right care at the right time

The service had a dedicated team to ensure children and their parents were able to access services quickly and appropriately.

- The 'single point of access' (SPA) team were able to provide signposting for any member of the public or health care professional that telephoned them during normal working hours and seek advice. Health visitors were contactable quickly by the team and appointments could be arranged by the SPA team although the service did not operate at weekends or Bank Holidays.
- The SPA supported the whole health visiting service including Family Health workers, Health Visitors and Children and Young People's Nurses. It included all administration tasks such as phone calls, letters, referrals and booking into clinics which had enabled the team to be more efficient and effective in the support they offer. The team had grown to 12 people and included nine Business Support Assistants, one apprentice, one Senior Business Support Assistant and a Compliance and Training Officer.

Community health services for children, young people and families

Good

- Between April 2018 and February 2019 the SPA team answered almost 38,000 calls. 98.10% of all calls were answered with only 1.8% of calls abandoned. The average time taken to answer a call was 12 seconds.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with all staff.

- Information on how to make a complaint or share a concern was available on the Lincolnshire County Council website. This was in conjunction with the Children's Health Complaints Management Pathway. The latter detailed the route a complaint should take and who was responsible for investigating it with the lead nurse/registered manager signing the response letter to the complainant. The timeline for this was ten working days.
- Compliments, complaints and concerns about the service were recorded on a log and shared with staff at monthly team meetings.
- Health visitors told us they did not receive many formal complaints and they tried to resolve them locally through early intervention
- The service had received four complaints in the 12 month period prior to our inspection. Each complaint had been investigated thoroughly, a feedback letter sent to the complainant and apologies given where appropriate. Feedback to the complainants had included the way the complaints could be progressed if they were not satisfied with the response
- Lessons learned from the complaints were appropriate. We spoke with members of staff who knew about the complaints and what actions had been put in place to prevent a similar occurrence.

Are community health services for children, young people and families well-led?

Good

Service vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

- The service's vision was to provide a service to the families in Lincolnshire and aspire to deliver a fully integrated health, early help, safeguarding and education system so they could holistically meet the needs of those families.
- Senior managers believed that families met the needs of their children; they did not consider their child's needs through an education, health or care lens. They felt families wanted a trusted professional who was able to meet all of their needs, bringing in and introducing other specialist colleagues when family's needs escalated. Children's public health nurses played an important role for families and therefore the service had integrated with other teams to provide a holistic offer.
- The leadership team told us relationship based practice, where the practitioner and the family had an open, honest, trusted and respectful relationship was more likely to achieve better outcomes for children and young people. They strived to ensure effective relationships were formed to maintain that relationship if needs or risks escalated.
- They believed they needed a bottom up and top down leadership style. They held regular locality based integration events, as well as organisational development opportunities to enable the workforce to share best practice, to network and to understand each other's roles.
- The lead nurse informed us it was the job of senior leaders to create an environment for the workforce to thrive, for example strong leadership, systems and policies to underpin outstanding practice, good supervision and workforce development as well as manageable caseloads.

Governance, risk management and quality measurement

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. The risk register did not reflect the risks we found during our inspection.

- The service was managed within Children's Services and overseen by the Children's Directorate Management Team.

Community health services for children, young people and families

Good

- The clinical governance of the service was monitored by the clinical quality group which had representation from public health and reported to the Lincolnshire County Council clinical governance board.
- The service also reported to the joint women and children's commissioning board, which had Lincolnshire County Council, public health and clinical commissioning group representation on it.
- A clinical governance and scrutiny group met monthly where, amongst other issues, all policies and procedures were discussed. This group fed into the clinical governance board and in turn fed into the quality assurance board.
- There were two risks for the children's health service identified on the risk register which included recruitment and staffing; the ability to recruit and retain staff in high risk areas. A scoring system was used and the assurance status was 'substantial' with existing controls to reduce the risk clearly outlined. Senior managers assured us there was a continuous recruitment programme in place.
- We asked senior managers why there were only two risks identified on the risk register. We were informed that if mitigations were in place for the risk and were having a positive impact they would not be placed on the risk register. We had concerns that the leadership team did not have full oversight of all the risks in the service, for example estate issues, poor morale and inconsistent infection control processes.
- Staff attendance at locality meetings was good. We reviewed meeting minutes and saw current performance, training, concerns and good practice examples were part of the agenda. When present, the lead nurse was able to give updates on the service overall.
- Although a county wide service, development plans for Lincolnshire Children's Centres were drawn up for individual localities. We reviewed one for Boston and South Holland from November 2018 to November 2019.The plan included actions for staff in the children's health service as well as those for social workers, early help workers and Children's Centre staff. Targets for each priority with timescales were clearly identified. For example increased levels of breastfeeding at six to eight weeks postnatally and reduction of the levels of obesity.

Leadership of this service

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- The service was led on a day to day basis by the Lead Nurse who was a qualified health visitor. The lead nurse was line managed by the Chief Commissioning Officer, Children's Services and overseen by the Interim Director of Education. The four localities across the county were managed by a locality manager whose line manager was the lead nurse.
- Health visitors spoke positively about local leadership and their locality manager. We spoke with all locality managers during our inspection and found they were very focussed on providing a good quality service that met the needs of children in their areas. Health visitors and children and young people's nurses told us locality managers were visible and actively involved in the daily operation of services. They had good oversight, were approachable and accessible and were constantly looking at ways to improve services for families especially in the most deprived areas of the county.
- Health visiting staff felt they had good leadership from their locality managers and practice supervisors. When we asked about visibility of the lead nurse, they told us she attended locality meetings where possible. On speaking with the lead nurse, she told us she tried to visit the children's centres and speak with staff as much as she could, but with the large geographical spread of services it was a challenge.
- Staff told us they felt well supported by their line managers that were always approachable.
- For staff who were employed as health care professionals, their annual registration fee was paid for by the service provider. Staff informed us this lessened the financial impact on them as individuals and ensured they were able to keep practicing as health care practitioners.

Culture within this service

Local managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Some staff feared retribution if they spoke out.

- Staff told us their immediate managers were very supportive and pro-active. There was a strong sense of support for each other amongst the health visitors, some of whom had moved areas to improve staffing/ decrease workloads because of shortages.
- We had received 11 contacts from staff before, during and following our inspection. We found staff morale was very low in some areas of the county with a number of staff experiencing a difficult transition moving from their previous organisation to Lincolnshire County Council. Managers were aware of the issues but could not provide immediate solutions as they required organisational level decisions. However staff continued to carry out their roles in a professional manner.
- Senior managers acknowledged some staff had been feeling vulnerable during the transition period. They had tried to give staff the opportunity to talk about their concerns by attending staff meetings and said they had an 'open door' policy should staff wish to speak with them. They also informed us they wanted to improve the services between health and social care as it would benefit children and families.
- Some of the staff who contacted us or who spoke to us told us they were frightened to speak out about their feelings because of retribution. We fed this back to senior managers at the end of our inspection.
- The provider had a whistleblowing policy in place which it described in the clinical governance framework for public health, adult social care and children's services as 'making an important contribution to patient safety'.
- A number of staff we spoke with told us they felt undervalued and that the provider was trying to mould them into a social services delivery model because the wider organisation did not understand the health services they provided.
- Staff did not have lone working devices at the time of our inspection although these were being planned by the service. The new devices would record the staff member's voice and would trigger an immediate response if there were any issues.
- Staff told us there was a planned 'supporting emotional health and wellbeing' conference being held in April 2019 which they were able to attend. Staff could also access the county council helpline if they required additional support.

Public engagement

There were feedback mechanisms in place to capture comments from parents using the service provided although none were available to review.

- Printed paper slips were available for parents to feedback their experience after they had attended the health visitor or any other session at each Children's Centre. They were able to leave these at the centre and were reviewed on a regular basis by staff.
- The feedback we reviewed was for sessions undertaken by other commissioned services within the Children's Centres. There was no direct feedback mechanism in place purely for health care provision and therefore we did not see feedback from on-going engagement with the public who had attended either health visitor sessions or had been supported by children and young people nurses brought together in a single document for the service as a whole.
- We received an undated provider survey from 76 parents which showed the vast majority of them were happy with the input they had received from staff. Of the 76 responses, 31 parents had left comments of which 24 were positive. Of the remaining seven, the majority of comments related to insufficient weighing clinics for newborns and lack of appointments.

Staff engagement

The service engaged well with staff although there was no individual staff survey for the children's health service.

- Locality managers provided updates at team meetings and quadrant meetings. We saw minutes of meetings which supported this, for example practice supervisors updated staff about the outcomes of the monthly clinical quality group. In addition, if staff required updating on issues between meetings, emails were sent to the staff.
- The service held 'listening' clinics for staff once a quarter. All staff in managerial roles told us they had an 'open door' policy and were contactable at any time.
- During annual appraisal meetings with staff, development opportunities and champion roles were discussed.
- The provider undertook a staff survey across all staff groups on an annual basis. However, there was no individual staff survey for the children's health service.
- Locality managers had used the experience and knowledge of their staff to influence service provision

locally in order to meet the needs of the communities they served. However, a number of staff we spoke with said when some issues were discussed, although they felt listened to they also felt senior managers had already made their mind up as to what the future of the service looked like.

Innovation, improvement and sustainability

The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.

- A dedicated health visitor visited the neonatal unit at a local hospital once or twice a month to meet with families and offer support prior to their baby being discharged. This had prevented families from feeling isolated.
- One health visitor had received additional training to support women with young children who were fleeing from an abusive relationship and who were being accommodated in a refuge.
- Because of a weekly donation of fruit, at one children's centre older children could take a piece of fruit when either they or their younger siblings visited the health visitors for reviews.
- Pre-owned children's clothes donated by parents were available at all the children's centres we visited where health visitor clinics were held. These items were checked and washed. Where washing machines were not available in the centres, staff washed them at home. This innovation was called 're-use and re-love'.
- Toy and book loans were available at a number of children's centres to improve the amount of stimulation that young children had.

Outstanding practice and areas for improvement

Outstanding practice

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- Toy and book loans were available at a number of children's centres to improve the amount of stimulation that young children had.
- Practice supervisors provided enhanced and accessible safeguarding and clinical supervison for staff.

Areas for improvement

Action the provider MUST take to improve

- The provider must take steps to ensure the Hygiene and Infectious Disease Procedures for Children's Centres is updated to reflect the provision of health services in those centres. In addition, that staff adhere to those processes especially in relation to the cleaning of both hard and soft toys.
- The provider must ensure all staff adhere to the bare below the elbows when in clinics and that staff wash their hands between children appointments in clinics.

Action the provider SHOULD take to improve

- The provider could ensure all clinic rooms for health visitors have independent access and are not used as a walk way between other areas.
- The provider could ensure that lone working safety measures are known and followed consistently by all staff.
- The provider could ensure staffing levels are increased in order to ensure the provider's own compliance levels of children's mandated contacts by health visitors are achieved.
- The provider could consider undertaking an annual staff survey for those involved in the delivery of health services.
- The provider could ensure the service risk register details all risks including those for the estate.
- The provider could ensure talks with the group of staff and the staff representatives involved in the current employment issue are taken forward and resolved as soon as possible.
- The provider could review their whistleblowing policy to support staff to raise concerns without fear of reprisal.

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 Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3) Safe care and treatment. How the regulation was not being met: People who use services and others were not protected against the risk of infection because of lack of robust procedures in place. Regulation 12 (2) (h)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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