Cheshire and Wirral Partnership NHS Foundation Trust

RXAX2

Community health services for children, young people and families

Quality Report

Redesmere
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1BL
Tel: 01244 364186
Website: www.cwp.nhs.uk

Date of inspection visit: 23 - 26 June 2015
Date of publication: 03/12/2015

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXAX2	Redesmere, Countess of Chester Health Park	Community services for children and young people	CH2 1BL

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Our overall rating for this service was Requires Improvement because:

Staff were familiar with how to report incidents and the relevant policy and procedure. However, the level of incident reporting was low, which could be indicative of staff not raising concerns appropriately. This was supported by examples of incidents that weren't reported, which limited the opportunity for learning. When incidents were reported, lessons learned were not shared consistently with the teams.

The service did not maintain accurate, complete and contemporaneous records in respect of each service user. Records were not accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe.

There was both a paper and electronic record for the majority of children in the service; however, there was no summary within the electronic record to identify historic concerns or issues. We also found that there was no reference in either paper or electronic records to alert professionals that there was another set of records for the child. In addition, it was identified that it would take a minimum of four hours for staff to retrieve archived paper records. Managers were not able to give assurance that staff would be able to identify historic concerns written in paper records and share the information with the relevant services in a timely manner.

Safeguarding and other alerts could not be removed from the electronic record system, which meant the system did not provide an accurate reflection of which children had a child protection plan in place or where there were current child protection concerns.

The risk identified in relation to the management of records was not on the divisional risk register and no risk assessment had been completed in anticipation of the records being moved into deep storage with an external company. Managers were aware of the concerns relating to removal of alerts from the electronic record but this had not been raised on the risk register and no risk assessment had been completed for this.

However:

Care and treatment was delivered in line with national guidelines and evidence based practice. Maternal mental health assessments were completed appropriately and fully documented using a recognised assessment tool.

There was effective multidisciplinary working evident across the service. School nurses had developed good working relationships with the schools in their areas. There was a health visitor attached to each GP practice to ensure effective working relationships. There were systems in place to ensure breast feeding mothers received the required support from suitably trained staff.

The children and young people's service was delivered by caring, committed and compassionate staff that treated people with dignity and respect. Staff actively involved young people and their parents and carers in all aspects or their care.

A range of services was provided by the teams both in the community and in schools. The teams aimed to provide a flexible service where possible. The school nursing service was in the process of designing a website called 'my wellbeing'. The work on this website was being undertaken with input from young people and the aim was for this to be launched in September 2015.

New initiatives had been established to meet the needs of people that use the services. Speech and language waiting times were being achieved with children waiting on average 11 weeks from referral to treatment which was better than the trust target of 13 weeks.

Summary of findings

Background to the service

Cheshire and Wirral Partnership NHS Foundation Trust provides services in the Cheshire and Ellesmere Port area for children, young people and families. Services provided by the trust include health visiting, school nursing, paediatric continence service, family nurse partnership, and speech and language therapy. The health visiting service visits families with children from birth to school age and school nursing services supports children from school entry until 16 years of age. Services are provided in clinic settings, as drop-in sessions, and within the school environment, and a large number of children and families are seen in their own homes.

The Family Nurse Partnership programme provides intensive support to young mothers and their children up to two years of age.

Community health services for children, young people and their families provide services in both the community and in schools, and teams aim to provide a flexible service where possible.

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director of Mental Health, Department of Health (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (Mental Health), Care Quality Commission; Simon Regan, Inspection Manager (Community Physical Health), Care Quality Commission

The team that inspected this core service comprised: Three CQC inspectors, a school nurse and a health visitor.

Why we carried out this inspection

We carried out this inspection as part of our comprehensive inspection of Cheshire and Wirral Partnership Foundation NHS Trust.

How we carried out this inspection

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

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

Before visiting the trust, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 23 and 26 June 2015.

We spoke with a large number of staff including the children and families clinical services manager and professional leads for both health visiting and school nursing. We also spoke with health visitors, school nurses, clerical officers, practice teachers, school health care assistants, family nurse practitioners, team leaders, speech and language therapists and infant feeding coordinators.

Summary of findings

We visited clinics in different areas of Cheshire. These included the Tarporley Health Centre, Wharton Clinic, Upton Village Surgery, Boughton Health Centre, Blacon Children's Centre, Upton Village Surgery, Stanney Lane Clinic, Great Sutton Clinic and Hope Farm Clinic.

During the inspection, we also held focus groups with health visitors and school nurses who worked within the service. We reviewed over 50 sets of records and used information provided by the trust and information we had requested to inform our inspection.

We spoke with children, young people, their families, relatives and representatives. We observed a breastfeeding support group, a well- baby clinic, a speech and language therapy clinic, home visits and school visual and hearing assessments.

What people who use the provider say

People who use the service told us they were treated with respect and dignity and that they had been communicated with in a clear and friendly manner.

One parent told us 'health visitors are brilliant'.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider must ensure that:

- Alerts can be removed from individual electronic records to ensure records provide an accurate reflection of current concerns.
- Medical records are kept in a way that allows professionals to easily access accurate, complete records for each child when required
- A full risk assessment is undertaken prior to the school nursing records being archived with an external company.
- The departmental risk register reflects the risks identified in relation to records management and that a full action plan is put in place to mitigate the risks.

The provider should ensure that:

- A record is maintained of the minimum and maximum fridge temperatures for each vaccination fridge on each working day in line with the trust's policy.
- All staff are aware of both the record keeping policy and the standard operating procedure within health visiting and school nursing and all staff are following these.
- Staff receive appropriate and sufficient record keeping training to reflect any changes in line with current practices.
- A full risk assessment is undertaken prior to the school nursing records being archived with an external company.
- The departmental risk register reflects the risks identified in relation to records management and that a full action plan is put in place to mitigate the risks.
- Lessons learned from incidents, from both within the team and trust wide, are shared with staff to avoid further occurrences.
- Services for children, young people and their families are consistently meeting key areas of the Healthy Child Programme, including a universal antenatal contact and two year developmental reviews.

Cheshire and Wirral Partnership NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Staff were familiar with how to report incidents and the relevant policy and procedure. However, the level of incident reporting was low, which could be indicative of staff not raising concerns appropriately. This was supported by examples of incidents that weren't reported, which limited the opportunity for learning. When incidents were reported, lessons learned were not shared consistently with the teams.

The trust had moved to electronic records approximately two years ago and paper records remained in use as they had not been scanned onto the system. There was no summary of any historic concerns with the child or family on the electronic system. On the majority of records there was no alert on the electronic system to identify that paper records existed and likewise there was no consistency within the paper records to identify that these were discontinued and had been transferred onto the electronic system. As a result, staff did not have access to a complete set of children's records within the bases so there was a risk that safeguarding information would not be shared appropriately with other professionals at the time it was required.

Children that were subject to a current child protection plan could not be easily identified from the alerts on the system. This was because alerts could not be removed or altered once they had been raised. Managers were aware of this concern but had not listed it as a risk on the departmental risk register.

Part of the major incident plan for the children and young people's service was that a paper record of significant information for the child and family would be kept in each base. However, in practice, this information was stored with

the paper records and was not available in each base so when records went for storage or archiving the health professional had no information about the child to use in the event of an IT failure.

Safety performance

- There were no serious incidents reported on the Strategic Executive Information System (STEIS) between 1 June 2014 and 31 May 2015 for the children and young people's service.
- There had been no pressure ulcers, falls with harm or catheter and urinary tract infections (UTIs) in the 12 months prior to the inspection within community health services for children and young people.
- Safety performance was a standard agenda item at team meetings. Quality dashboards (showing a snapshot of safety and quality performance) were discussed for previous months and monthly contacts were discussed also.

Incident reporting, learning and improvement

- Incidents were reported via an electronic incident reporting system. A policy was in place to support this, which staff were familiar with.
- Feedback from incidents was not consistently given to staff across the service. Feedback could be automatically sent to the reporter, via the incident reporting system, once an incident had been investigated and closed, however this was not used in practice. There was no evidence in the last six months of team meeting minutes that lessons learned from either the service or trust wide were shared or discussed with staff. Staff and managers told us that lessons learned were shared at team meetings and via email.
- School nursing staff were not familiar with the principles of duty of candour. However, health visiting staff could clearly articulate their understanding of it and its requirements.
- Out of 1,027 incidents reported within physical health services between 1 April 2014 and 31 March 2015, only 44 were reported in children and young people's services. The incidents that were reported were predominantly about IT issues, which resulted in no harm. However, other incidents that staff told us about, such as delays in the completion of development checks, were not reported on the system. This meant that the number of incidents in this service was inaccurate and lessons may not be learnt from consistent issues that require further investigation

Safeguarding

- Staff were familiar with the safeguarding policy and procedures and had an effective working relationship with the trust's safeguarding team.
- Level three safeguarding children training statistics for the division showed that 95% of staff had completed their training, which was higher than the trust target of 85%.
- Health records for children and families were unreliable and not fit for purpose in relation to safeguarding. There was an electronic record system in place that had been implemented approximately two years ago. Paper records were also used for children born before the implementation of this electronic system but the paper records had not been scanned onto the electronic system. As a result, the service used both electronic and paper records for all children over two years of age. However, the records did not cross refer to one another. They did not highlight that another set of records was in existence or any historic concerns. The records we reviewed were not compliant with either the trust policy or the standard operating procedure. This issue did not affect children who were new to the service as they would only have an electronic record but it could affect a high number of children who were born before the implementation of the electronic record as these records should be kept into adulthood.
- Records did not always reflect an accurate account of current safeguarding or child protection concerns. Staff could put an alert on records where there were concerns that needed highlighting to other health professionals, such as children on a child protection plan or violent warning markers. However, staff and managers identified there was no way of removing these alerts from a child's records once they had been put in place. There was nothing written in the trust's policy about the review and removal of alerts or warning markers when they were no longer valid. This resulted in child protection alerts and violent warning markers being recorded indefinitely, which was against the principles of the Data Protection Act 1998 and potentially diluted the value of the markers as it was unclear which marker was active or inactive at any given time.

Requires improvement

Are services safe?

- School nurses were always a member of core groups following initial child protection conferences. They subsequently attended all core group meetings, regardless of whether there were any health needs identified, which may not be the best use of the school nurses time. It had also been identified within team meetings that some areas of the trust had a high number of families where safeguarding concerns had been identified. This had an impact on other areas of work that school nurses were able to complete, such as public health initiatives in schools.
- School nursing staff explained that there were some issues with receiving records in a timely way for children who transferred into the trust's service from other areas. Staff gave several examples of where they had attended initial child protection case conferences without a full report due to difficulties with them obtaining the child's records. In these cases, an accurate school health history could not be provided to the case conference.
- Child protection supervision was embedded within the health visiting and school nursing services. Evidence was seen of good documentation within the child's records of the supervision sessions. However, the trust policy suggested that staff were expected to also complete 'children looked after' supervision but staff did not always receive regular supervision for children looked after on their caseload due to a lack of trained supervisors. All health visitors and school nurses who have direct input with families that have safeguarding concerns should have regular supervision to ensure the correct procedure is followed and also to provide emotional support for staff. This is a national requirement and supervision is generally undertaken by peers or a member of the safeguarding team who have undertaken additional training.
- Safeguarding was a standard agenda item on team meetings. A member of staff from the safeguarding team attended the meetings and gave regular updates.
- We attended a home visit with a health visitor and noted that the mother was not asked about any other adult living at the property. In addition, we reviewed some records where there was no documentation as to whether this was asked at the visit. This is contrary to the safeguarding of children policy for the trust, which states that 'all staff who have contact with families should obtain the details of any adult who is in regular contact with the child'.

Medicines

- School nurses worked to patient group directions in relation to the school immunisation programme. These allow a nurse to give prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. Appropriate systems were in place for the management of this.
- The vaccination fridge at Lache health centre was in a locked room not accessible to the general public in line with the trust's policy. However, although the current temperature of the fridge was checked and recorded daily, the temperature range was only checked fortnightly. This was against the vaccination policy, which identified that 'a daily record log must be taken of the minimum and maximum temperatures of the fridge on each working day'. Consequently, staff were not alerted if the temperatures of the fridges were not within the required range of between 2 and 8 degrees Celsius (the National Patient Safety Agency recommended range). Any change in temperature out of the recommended range could potentially make vaccines in the fridges unfit for use.
- Vaccines in the fridge were otherwise stored in line with the trust's policy.
- Data provided by the trust showed that 90% of staff in the children and young people's service had completed medicines management awareness training, which was higher than the trust's target of 85% compliance.

Environment and equipment

- The departmental medical devices register was kept centrally and was up to date and completed accurately. It showed that all medical devices kept within the service were calibrated appropriately. Weighing scales had been subject to portable appliance testing to ensure they were safe to use.
- Medical device alerts were sent out via email and also discussed at team meetings to ensure that all staff were aware of what the alert was and the required action. Medical devices alerts are the prime means of communicating safety information to health and social care organisations and the wider healthcare environment on medical devices. They are prepared and

distributed nationally by the Medicines & Healthcare products Regulatory Agency (MHRA) and are distributed nationally for each healthcare setting to implement any requirements.

- Risk assessments were in place for each of the well-baby clinics offered by the health visiting service. We reviewed these and found that they were completed appropriately.
- Each of the clinic settings that we visited were visibly clean and in a welcoming environment with age-appropriate toys available.
- School nurses reported a lack of resources for completing public health education in schools, such as DVDs and visual aids for demonstration. There had previously been more resources available to them but the staff were not clear where they had gone. This had an impact on the public health initiatives that the school nurses were able to deliver.

Quality of records

- Although paper records were used for children born before the implementation of the electronic system, the paper records had not been scanned onto the electronic system and there were no plans for the trust to do this. This meant that a complete set of records was not accessible at all times.
- Neither the electronic records nor the paper records followed the trust's standard operating procedures for record management within both the school nursing and health visiting services. The procedures stated that 'a single line should be drawn through the record with the words 'closed paper record, electronic records commenced.' However, this had not been done in any of the paper records we reviewed. Electronic records also were not in line with the procedures in that they did not identify that a paper record existed for the child.
- Managers told us that the trust's record management policy should be followed as well as the standard operating procedures. However, from all of the records that we reviewed, we observed that this policy was not being adhered to either. This was particularly in relation to an alert sticker that should have been present in the paper records to identify that an electronic record had commenced.
- At the time of the inspection the trust were in the process of archiving school health paper records for children following the universal programme, as identified in the healthy child programme. The healthy child programme is the universal preventive programme that begins in pregnancy and continues through childhood, predominantly led by health visiting and school nursing services. It is an evidence based programme of developmental reviews, screening, immunisations, health promotion and parenting support. The universal programme is for children and young people aged 0-19 that have no additional needs. Staff expressed concern about the archiving process and what this meant to them. The school paper health records were due to go into archive with an external company and to retrieve the paper records, would take a minimum of four hours. The children and young people's service had not undertaken a risk assessment for this as the managers said it would be undertaken by the external company.
- Managers were not able to give assurances that if staff were asked for information regarding a child who had historic concerns written in the paper records they would be able to identify this and share the information with the relevant services.
- The records for children following universal plus and universal partnership plus programmes would be kept at a centralised base and not with the named school nurse. This meant that for children with complex needs or children at risk of harm there was no complete record accessible to the relevant staff at all times. Children following the universal plus programme were children that required some additional support. Children following the universal partnership plus programme required support for complex needs and/or additional needs in partnership with relevant agencies.
- The handover sheet identified personal information about the child, such as name, date of birth, family members and any current concerns. The sheet did not ask about any previous concerns. Staff advised that they were including previous concerns but that this was at the discretion of the individual health professional. The paper records were not transferred to the school nurses until the child had started school. The plan was for this to be rolled out to all teams in September 2015 if the pilot was successful.
- Regular record-keeping audits were undertaken in the children and young people's service. Subsequent evaluations and action plans were written and shared with staff. However, as the audit tool was a generic one it

did not capture relevant information required to identify concerns that were specific to the children and young people's service, such as the disjointed records and alerts.

- Whilst reviewing the records in one base, two sets of records were found to be misplaced. One set was found after searching the office where it had been misfiled. However, the second set of records was not located during our inspection. Within the same base a set of paper records that we reviewed held the notes of three children in the same folder. The correct location of the paper records for two of the children was not known.
- The record management policy said that tracer cards should be used when records were taken out of the filing cabinets to identify where the paper records were. However, we saw that tracer cards were not always used or completed appropriately, meaning that if the records were required there was no way of the health professionals easily locating them. The clerical team used a different system with a spreadsheet listing where records had been sent, which meant that records were easily traceable if the clerical team had sent them out.
- A template was used for care plans on the electronic system, which were completed and reviewed appropriately. However, there was no facility on the system to update the care plans once they were in operation as the templates would not allow for this. This meant that a new template had to be completed each time there was a change to a care plan. Staff reported that this was a time-consuming process.
- Speech and language therapists and the continence service used the same electronic system as the health visiting and school nursing service, which allowed continuity of care between the services and better multidisciplinary working.
- There were some difficulties with the school nursing team at Wharton Primary Healthcare Centre being able to access the school health records. This was due to the school nursing team being transferred over to the trust in January 2015 and the records remaining the property of a neighbouring trust. The management team were aware of the difficulties and told us they were working with the neighbouring trust to rectify the situation.
- Staff identified concerns around delays in receiving records from other areas outside of the trust. The clerical team kept an accurate record of requests for records and reviewed any outstanding requests monthly. However, a delay in accessing records meant that school nurses were not aware of historic concerns for some of these children.
- Statistics provided by the trust showed that 98% of staff within the core service had completed training in health record keeping, which was higher than the trust target of 85% compliance. However, the expectation was that all staff completed this training as one-off training and did not attend it regularly to keep them up to date.
- Staff completed refresher information governance training each year. At the time of the inspection, 80% of staff had completed this training, which was slightly lower than the trust target of 85%.

Cleanliness, infection control and hygiene

- Staff were aware of infection prevention and control guidelines and where this guidance could be accessed.
- We observed that equipment was cleaned using the trust's protocols and that equipment such as weighing scales and changing mats was cleaned between each baby-weighing at the clinics.
- Good hand washing techniques were observed and alcohol hand wash was used by staff to decontaminate their hands. Hand wash posters were displayed in prominent positions to act as a reminder for people to wash their hands thoroughly. There were also posters to advise on the correct method of hand washing.
- Some 72% of staff had completed training in infection prevention and control at the time of the inspection, which was lower than the trust target of 85% compliance.

Mandatory training

- Staff received mandatory training in areas such as safeguarding children, fire awareness, equality and diversity, and moving and handling.
- Training was delivered centrally either face to face or online training through the intranet. There was an expectation that staff were to keep up to date with their own mandatory training and reminders were given to staff at team meetings.
- Staff reported that they were supported to complete their mandatory training and felt they had enough time to complete it.

Requires improvement

Are services safe?

- The overall compliance for yearly mandatory training for clinical staff, which included information governance, basic life support, safeguarding children level three and infection prevention and control was 78%, which was lower than the trust target of 85%.
- Staff were also required to complete some mandatory training modules every three years, which included conflict resolution, mental capacity act and safeguarding family, levels one and two. Data provided by the trust showed that 93% of clinical staff had completed this training, which was higher than the trust target of 85%.
- The trust also provided one-off mandatory training modules which did not need to ne renewed including fire safety, moving and handling, equality and diversity, emergency planning and fraud. Trust data showed that 94% of clinical staff had completed this training, which was higher than the trust target of 85%.

Assessing and responding to patient risk

- Within school nursing there was a pilot being undertaken at the Wharton base to operate a duty rota. This involved the duty school nurse dealing with high volumes of calls. Staff raised concerns that, due to capacity issues, they were not able to answer all of the routine calls as they prioritised the safeguarding calls. School nurses said there were a lot of enquiries from social care about health information for children. There was evidence of telephone calls made several days earlier that had not been responded to. This meant that school nurses were not responding to all phone calls and could potentially miss calls relating to safeguarding and other significant issues if this wasn't initially identified on the answering machine.
- A further concern about the duty rota was that emails were sent to several school nurses across the trust based in different offices. Staff said it was very time-consuming to filter through the significant emails to see which area the children were from. For example, an invitation to attend an initial child protection case conference had been sent to several school nurses and the duty school nurse had no way of identifying if it had been picked up by the named school nurse. This meant there was a risk of important information being missed, particularly in relation to safeguarding.
- Environmental risk assessments for vaccination sessions were completed in the school settings on arrival. These identified areas including whether it was a suitable environment and was in line with health and safety requirements, that anaphylaxis equipment was accessible, hand washing facilities were available and there was adequate privacy.
- Risk assessments were completed for each of the health visitor well baby clinics to ensure that the environment was safe for children and their families.

Staffing levels and caseload

- There were four full-time health visitor vacancies at the time of the inspection. The service had experienced recruitment difficulties in that the posts had been put out to advert in April 2015 but there had been no successful appointments made. There was also long-term sickness absence within health visiting, which impacted on the skill mix.
- There was an inequitable distribution of community nursery nurse and staff nurse hours in the health visiting teams. This had been reviewed and there was a service redesign taking place to ensure a better distribution of skill mix across the health visiting teams.
- The health visiting service was also going through a process of redesign in respect of part time vacancies. There were plans to replace all staff that left the service with staff working a minimum of 22.5 hours per week. It was felt that this would better meet the needs of the service.
- Health visitors' caseloads only included babies following the universal programme until they were six weeks old, after which they were placed on the corporate caseload. This meant responsibility for their care was shared within the team. Staff said that efforts were made to reallocate the family to the same health visitor for any future intervention but that this was not always possible. This could create a lack of continuity of care for the families.
- The speech and language therapists had equitable caseloads across the service and staff felt that their workload was manageable. A review of the caseload numbers had been undertaken by team leaders to ensure equity across the team.

Managing anticipated risks

- Lone working policies were in place and staff followed them. Staff could describe the trust's protocols for arranging and carrying out home visits. Lone working arrangements were discussed at team meetings.

Requires improvement

Are services safe?

- The electronic records alert system showed any potential risks to staff when carrying out visits, including any domestic violence concerns. However, due to the concerns previously described in the report around non-removal of these alerts, this system did not accurately reflect current risk.
- Central Alerting Systems (CAS) alerts (web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care) were sent directly to all relevant staff via email. These were also followed up by discussion at the team meetings.

Major incident awareness and training

- The service had plans to manage and mitigate anticipated major incident risks, including seasonal incidents such as bad weather or a flu pandemic.
- Part of the major incident plan for the department was for each child to have a family health record filed at the front of the paper records. This was to ensure that in the event of a system breakdown, information about a child would still be available. It was noted that every child had one of these records, filed at the front of the paper records. However, this was not removed from the records when they were sent for storage or archiving. Therefore for children whose paper records had been archived or stored away from the base there was no accessible record of the child in case of a major incident with IT.

Good

Are services effective?

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

Summary

The service provided evidence based treatment and care. NICE guidance was followed and used to ensure care and treatment was delivered in line with best practice. Maternal mental health assessments were completed appropriately and fully documented using a recognised assessment tool.

There was effective multidisciplinary working evident across the service. School nurses had developed good working relationships with the schools in their areas. There was a health visitor attached to each GP practice to ensure effective working relationships. There were systems in place to ensure breast feeding mothers received the required support from suitably trained staff. Robust preceptorship and a monthly critical friends group took place within the health visiting service, which gave new health visitors an opportunity to discuss any concerns they had. This was led by the professional development lead for the service who also addressed any identified training needs within the sessions. Laptop computers were available within the service. However, there were not enough of these for each member of staff. There were difficulties with connectivity when staff were not in their bases. This meant that staff did not always have access to the right information in a timely manner.

Evidence based care and treatment

- The healthy child programme (HCP) was delivered by health visitors, school nurses and family nurse partnership (FNP) nurses. Staff in the health visiting service were trained in the use of the Solihull approach. The Solihull approach is evidence based and is a psycho-therapeutic approach to working with children and families.
- Evidence based tools were used by health visiting and family nurse partnership teams to assess a child's development. An example of this was the tool that was used to complete developmental assessments was Ages and Stages Questionnaire (ASQ), which is a nationally recognised, evidence-based tool and is used within the family nurse partnership programme nationally.
- Maternal mental health assessments were completed by the health visitors using National Institute for Clinical Excellence (NICE) guidance. Records showed these assessments had been completed and fully documented.
- NICE guidance was a standard agenda item for both health visiting and school nursing team meetings. Any new, relevant guidance was discussed at the meeting and this was well documented.
- The speech and language therapy department used the Malcomess care aims model. This model uses labels to guide the planning, delivery and outcome measurement of care. This involves the use of one of seven labels which clarify and make explicit the purpose of each episode of care undertaken with a client. This ensured consistency and standardisation in the approach used by the therapists and also ensured evidence based care and treatment was being delivered.

Nutrition and hydration

- The trust had an infant feeding coordinator who provided training and support to the health visiting team. The coordinator worked very closely with the local acute trust's infant feeding coordinator and multidisciplinary training was delivered across the two trusts.
- All the health visitors had completed breastfeeding training and each team had a breastfeeding champion.
- The infant feeding coordinator provided feedback to the health visiting teams regarding breastfeeding figures and action plans.
- The trust was working towards stage 2 status of the baby friendly initiative. There was no date set at the time of the inspection as to when the trust would go through the assessment process. The baby friendly initiative is a worldwide programme of the World Health Organization and UNICEF. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- There was a local 'buddy' system in place that health visitors could refer into to offer support to breastfeeding

mothers if required. The buddy system was run by volunteers that received training and had to meet the criteria that they had breastfed their own child for a minimum of six weeks.
- The trust measured exclusive breastfeeding rates, which were at 28.5% within quarter 4 of 2014-2015. This was higher than the national figure of 24%.

Technology and telemedicine

- There were laptop computers known as 'tough books' available at each base for staff to use. However there were not enough of these available for each member of staff.
- Staff reported having frequent difficulties with connectivity with the 'tough books' whilst conducting home visits or whilst in the school environment. They felt this was time-consuming as staff had to document their contacts on return to the office and they did not have the right information available to them as it was required.

Patient outcomes

- School nurses raised concerns that it was approximately two years since they received any vaccination data to identify if they were meeting the trust's targets on vaccinations. However after reviewing the minutes of the school nursing meetings it was seen that this information was discussed. This showed a discrepancy around what staff understood had been discussed at meetings and what was documented as having being discussed. Trust data showed that vaccination rates were 89% for the Human papilloma virus (HPV) and 92% for Combined Diphtheria (low dose), Tetanus, and Inactivated Poliomyelitis Vaccine (Td/IPV).
- The family nurse partnership had annual reviews and was meeting all the fidelity goals. The fidelity goals cover 4 main areas which are recruitment, retention of clients (measured by attrition rates), amount of programme received and programme content received.
- The delivery of the Healthy Child Programme was monitored for the service. Data from quarter 4 of 2014/15 showed that 94% of births were visited by a health visitor within 14 days, whilst only 80% of children received a development assessment between the required ages of two and two and a half. Managers identified that this lower level was as a result of the appointment system and that there was very limited clerical assistance within the health visitor teams.
- School nurses and health visitors told us that some elements of the programme, such as antenatal contacts, were not undertaken in line with requirements and that health promotion and public health activity were not delivered consistently. This was mainly due to the existing health visitor vacancies and the amount of work spent with safeguarding families within school nursing.

Competent staff

- Trust data showed that 76% of staff within this service had received their appraisal which was lower than the trust target of 85%. However, a team leader reported that all staff in her team were up to date with their appraisals with the exception of staff members who were on long term sick leave or maternity leave.
- Staff spoke very positively about the clinical peer supervision that they had every six weeks and were very clear of the value of it.
- There was no robust competency framework in operation within the service, particularly in respect of the distribution of nursery nurses and staff nurses within the health visiting team. Team leaders had identified this as an area for development and work was due to be undertaken in respect of assessing competencies.
- Robust preceptorship and a monthly critical friends group took place within the health visiting service, which gave new health visitors an opportunity to discuss any concerns they had. This was led by the professional development lead for the service who also addressed any identified training needs within the sessions. An example of this was jaundice in the new-born training that had been delivered as a result of an identified need.

Multi-disciplinary working and coordinated care pathways

- Evidence was seen of good multi-disciplinary working within the FNP and how the families were integrated with universal services. There was a graduation pathway into universal services when the child reached two years of age.

Good

Are services effective?

- The family nurse partnership supported the health visitor training for the new ASQ developmental assessment for 0-5 year olds. This ensured consistency across the trust in the completion of development assessments.
- The health visiting team and local authority worked together to implement a training group called 'baby matters'. This was a targeted group for families on the universal plus or universal partnership plus programmes.
- Each GP practice had a link health visitor attached to them, which promoted effective communication and better working relationships. This health visitor liaised with the GP practice to share information as a two way process. The majority of electronic records were linked with the GP systems to enable the professionals to access relevant records and also ensured continuity of care for the families.
- One health visiting team had good links with the local military barracks and delivered a community well baby group from there. This group was in its infancy but had received good parent feedback.

Referral, transfer, discharge and transition

- Health visiting teams provided a service to children from 0-5 years at which stage children would then move to the school nursing teams from 5-19 years. There was a pilot scheme in place within one team of health visitors whereby when a child reached the age of four years six months they would be transferred over to the school nursing service. The health visitor would transfer the child over to the school nursing service on the electronic records system and would complete a handover sheet that was attached to the front of the paper records. If the child was following the universal plus or partnership plus programme then this process also involved a face to face handover. The health visitor retained responsibility of the child until they started at school.
- Staff described instances where school health records had not been received for children that had moved into the area despite the records being requested on several occasions. In some instances school nurses had attended initial child protection case conferences without the relevant school health information. The trust was aware of this risk and had a procedure in place for the school health clerical staff to follow up on any records that did not arrive. Each set of records that did not arrive were followed up on a monthly basis.
- Concerns were identified in terms of communication with an independent midwifery service and health visitors not being made aware of all antenatal women within their area. This prevented the health visitors conducting an antenatal contact. This concern had been reported via the incident reporting system and was being investigated jointly by the team leader of health visiting and the midwifery lead for the service.
- GPs informed the health visiting team of any new patients under school age that registered with their practice. There was a robust system in operation where health visitors also received a print out from the practice on a monthly basis of all new registrations under five years of age. This ensured that all new children in the area were allocated to and contacted by a health visitor.

Access to information

- As there were insufficient 'tough books' to allocate one per member of staff and also connectivity difficulties, staff were not always able to access records whilst in clinic settings or during family visits. We did not observe any staff using this technology during the inspection and staff told us they didn't often use it due to the difficulties identified.
- Some staff were based in GP practices and were connected via the GP network. This meant that staff were not able to access the trust's policies and procedures and incident reporting system whilst they were in their own offices. Subsequently staff had to travel to other bases to access trust information.

Consent

- Consent forms for vaccinations within school health were sent out to parents and carers prior to the vaccination sessions to inform them of the appropriate details and to obtain the relevant consent.
- Staff used the Gillick competency and Fraser guidelines (used to decide whether a young person is mature enough to make decisions) to balance young people's rights and wishes with the responsibility to keep children safe from harm.
- Staff informed us that the health visiting service used implied consent. At the primary visit parents were given

an information leaflet regarding information sharing. However there was no reference to any discussions around consent or information sharing being documented in the child's records.

- For the FNP, clients received a recruitment visit with one of the team who outlined the value of the programme. After this visit if the client agreed to join the programme, consent was subsequently documented.

Good

Are services caring?

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

Summary

Children, young people, families and carers told us that they received compassionate care with good emotional support. Parents told us that they felt informed and involved in their child's healthcare.

Staff were child and family focused and they looked at the family unit when completing their assessments. Good interactions were observed between staff and children, young people and their families.

Compassionate care

- Children, young people, their families, relatives and representatives were positive about the care and treatment provided by staff. Parents at a baby clinic described positive experiences with the health visitors and explained how they handled babies with compassion and care. Children, young people and those close to them were happy and relaxed in the department and staff interacted well with them.
- All parents and children that we spoke with were very happy with the service that they received. They found the staff to be very approachable and knowledgeable.
- Staff were very passionate about the care that they provided and were very clear on the importance of engaging the families with all interventions that were offered to them.
- There were separate rooms in the clinics that we visited to allow for parents to speak confidentially with members of staff if required.
- Some parents described some discrepancies in the advice they were given by different health visitors dependent on the clinic that they had attended. Parents told us they found this unhelpful and confusing.
- The NHS Friends and Family test was completed within paediatric continence and speech and language therapy, which showed that 100% of service users were either likely or extremely likely to recommend the service to the friends or family. This was not completed within health visiting or school nursing.

Understanding and involvement of patients and those close to them

- Good interaction was observed in the speech and language therapy clinic. Children were offered choices of interactive games to play and were given a lot of praise and encouragement.
- Examples were seen of personalised care plans written in partnership with parents, carers and schools.
- Parents were involved in the care of their children, with procedures being explained to them clearly. Examples of this were seen when staff were completing developmental assessments.
- During home visits, health visitors were observed to be approachable and sensitive to the parents' or carers' needs.
- Procedures that were undertaken within a special school setting were explained to the children in a way that they understood. The staff were responsive to the needs of individual children. In one vision screening session, an example was seen where a member of staff adapted the session to meet the needs of a child with autism.

Emotional support

- Parents were encouraged to continue working with children at home for their speech and language development.
- Some parents that we spoke with reported seeing different health visitors at each contact. This prevented the parents from building up a positive relationship with the health visitor and could potentially make it more difficult for mothers to disclose issues such as domestic violence and perinatal mental health. This had not been identified as an issue by the health visiting service.
- Health visitors offered support to mothers who suffered from postnatal depression. This was well documented within the electronic records.

Good

Are services responsive to people's needs?

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

Summary

A range of services was provided by the locality both in the community and in schools and teams aimed to provide a flexible service where possible. The school nursing service was in the process of designing a website called 'my wellbeing'. The work on this website was being undertaken with input from young people and the aim was for this to be launched in September 2015.

New initiatives had been established to meet the needs of people that use the services. Speech and language waiting times were being achieved with children waiting on average 11 weeks from referral to treatment which was better than the trust target of 13 weeks. School nurses were not conducting regular public health education sessions with school groups due to capacity issues; however, they were doing more targeted work to meet specific needs.

Planning and delivering services which meet people's needs

- The FNP was doing a piece of work with children's centres and baby clinics which was coordinated with the local authority. This identified clients that had difficulty attending universal services because they lacked confidence and felt stigmatised. Therefore a group for young parents and their children had been set up, with both FNP families and non-FNP families. This group was being evaluated by looking at skills at the beginning of attendance and at the end.
- Parents and young people were directed to online support for areas, such as breastfeeding and nutrition. This allowed appropriate information to be accessed as required to complement the advice given by health professionals.
- School nurses were not conducting regular public health education sessions within schools due to capacity issues; however they were doing more targeted work to meet specific needs. The service was also exploring other opportunities for public health work. This included working with a local third sector organisation, which was looking at offering public health education within schools.
- The school nursing service was in the process of designing a website called 'my wellbeing'. The work on this website was being undertaken with input from young people and the aim was for this to be launched in September 2015.
- Health visitors and school nurses did not perform population health needs assessments in order to identify specific health needs particular to a school or location.

Equality and diversity

- A translation service was used for families whose first language was not English. However, on reviewing the records, there was no evidence of translation services being offered to families or whether it was required.
- An example was seen of a mother who had moved to the United Kingdom from Europe. She described how her health visitor had helped put her in touch with other mothers from the same country as herself to enable her to have peer support and easier access to groups. The mother had been isolated prior to this as she had not known anyone in this country.

Meeting the needs of people in vulnerable circumstances

- Public health initiatives were targeted to meet specific needs that had been identified to the school nursing team, such as contraception and childhood obesity.
- There was a 'baby matters' group in operation. This involved joint working with the local authority and was to deliver targeted work. The group covered areas such as the introduction of solids, sleep and crying and minor ailments. This group was a relatively new initiative but had been evaluated and changes had been implemented as a result of parent feedback.
- Work had been undertaken setting up a community clinic in the local military barracks which involved joint working with the Military of Defence to provide a well-baby clinic from the barracks. This provided better engagement with the families on the barracks and provided integration with the local community.
- There was a link school nurse for each special school within the area. These school nurses worked closely with the parents, children and staff to provide individual

care plans for the schools and parents to be working towards together. An example of this was in a school for children with autism where the school nurse developed individual care plans to support with toileting needs. This received positive feedback from the school and parents.

Access to the right care at the right time

- The division was not providing a 7-day service for children and young people and there were no plans to move towards this.
- The school nursing service had moved to cover the service all year round to ensure that support for safeguarding families could be provided during the school holidays. School nurses had previously worked term time only.
- The speech and language therapy department aimed to see all children within 13 weeks from referral to treatment. This target was being achieved with the majority of children being seen within 11 weeks at the time of inspection. Priority children, such as children looked after and safeguarding children were seen within the speech and language therapy department within eight weeks. Children with dysphagia and dysfluency were seen within 48 hours of the referral being received. There were also speech and language therapy support groups for children to attend in addition to their clinic sessions. This ensured that children were given support earlier than just receiving individual sessions.
- To ensure that the waiting list targets were being met, children that did not attend (DNA) the initial appointment were discharged and a letter was sent to the parents and the referrer advising of the non-attendance. If the child did not attend an appointment after the initial assessment and they were offered a programme of therapy, they were subsequently sent a letter identifying that the parents had to telephone to rebook the appointment within three weeks. The child was discharged from the service after this time if the parents did not make contact. They were sent a letter informing them of the discharge. This was more flexible for vulnerable children where the service contacted the referrer to inform them of the DNA.
- The Healthy Child Programme was managed between the health visiting and school nursing services. The heath visitors were not compliant with elements of the healthy child programme in terms of antenatal contacts and developmental assessments. An antenatal contact was not being routinely offered to all pregnant women. We were informed that antenatal contacts were being offered to mother's identified as a greater risk in their pregnancy or where safeguarding concerns had been identified.

Learning from complaints and concerns

- The parent of each child that attended the continence service was given a patient information liaison services (PALS) booklet on their first appointment which identified how they could raise a complaint if necessary.
- Verbal concerns were captured using a trust template, which staff were familiar with. Information from these was evaluated to identify any trends.
- Staff felt they were supported if a complaint was made against them. However, they were not involved in the investigation or the outcome of the complaint.
- Complaints were discussed as a standard agenda item in team meetings.

Requires improvement

Are services well-led?

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

Summary

The management of records was not on the divisional risk register. Managers were aware that alerts could not be removed from the electronic system but they had not identified this as a risk and had not completed a risk assessment or placed it on the risk register. In addition there had been no risk assessment completed in anticipation of the records being moved into deep storage with an external company. Managers did not plan to do this as the external company was completing one.

Regular record keeping audits were undertaken but these did not look at key areas specific to the children's and young people's service. These audits did not identify whether the child had an additional set of records or whether there was clear identification in the paper records to alert the professional that this record had transferred to electronic records. Managers were aware of this but nothing had been put in place to address it.

The trust was not monitoring performance or working towards any target count, as identified by NHS England in terms of antenatal contacts. All pregnant women should be offered an antenatal contact but the trust was unable to provide assurance of their performance within this area as they only collected raw data.

School nursing and health visiting services were managed by the same clinical lead. However there were differences in the management of both of these services. For example, we found that health visitors were very aware of the service vision and strategy, they received monthly team meetings chaired by the clinical service manager and they were aware of the risks contained in the departmental risk register. However, within the school nursing service, staff were not aware of the service vision and strategy, they received bimonthly team meetings but staff were not aware of the risks contained in the departmental risk register.

There was no evidence from minutes of team meetings of any lessons learned from incidents or complaints being shared.

Staff in health visiting services were clear about the management structure and felt that leaders were visible and supportive. However, this was not the case in school nursing services.

Service vision and strategy

- Health visitors were very aware of the service vision and strategy. However, within the school nursing service we found the staff were not aware of the vision and strategy for the service.
- Within the children and young people's services there were a number of pilots being undertaken, including the 'duty' school nurse, a corporate caseload for school nursing and the handover from health visitors to school nurses. However staff were not aware of when or how the pilots would be implemented across the service or of how the impact of the pilots was being captured.
- Work was being undertaken by the clinical service manager to lead the health visiting service transition to the local authority and staff were knowledgeable about this.

Governance, risk management and quality measurement

- Records management was not on the risk register at the time of the inspection despite the concerns we identified. Managers were aware that alerts could not be removed from the electronic records system. We were informed that records management had previously been on the risk register but had been removed as there was an action plan in place.
- No risk assessments had been completed for the management of records that were due to go into deep storage. Managers did not plan to do this as they stated that the risk assessment would be completed by the external company.
- Regular record keeping audits were undertaken across the trust but these did not look at key areas specific to the children's and young people's service. For example, these audits did not identify whether the child had an additional set of records or whether there was clear identification in the paper records to alert the

professional that this record had transferred to electronic records. Managers were aware that records audits did not look at this type of information but had not put anything in place to address it.

- There was a mixed view from school nursing staff regarding the frequency of team meetings and what was discussed at these meetings. Some staff told us there had not been any staff meetings for school nursing and other staff told us they regularly attended meetings. Some staff felt these meetings were not relevant to them whilst other staff told us that items discussed on the school nursing agenda included audits, complaints and lessons identified from incidents. After review of the meeting minutes, it was evident that these meetings did occur bi-monthly and were well attended by school nursing staff, however on review of the last six months of minutes; we noted that no lessons learned from complaints of incidents were discussed.
- The health visiting service had a more structured approach to team meetings. Health visitors had a monthly team meeting where a minimum of one health visitor per base was expected to attend and give feedback to their team.
- Incidents were discussed at health visitor team meetings, however no evidence was seen within the minutes of any lessons learned being shared.
- The trust was not monitoring performance or working towards any target count, as identified by NHS England in terms of antenatal contacts. All pregnant women should be offered an antenatal contact but the trust was unable to provide assurance of their performance within this area as they only collected raw data. Health visitors and managers told us that they only routinely offered antenatal contacts to women identified as a high risk in their pregnancy or where safeguarding concerns had been raised.
- Managers reported that work was being undertaken to address the health education agenda within school nursing. However school nurses did not know about this work or if any plans were in place to enable full delivery of the Healthy Child Programme for children aged four to 19 years for example, sexual health sessions in schools, smoking cessation, accident prevention and drug and alcohol awareness.
- Staff within health visiting were familiar with the departmental risk register. However, this was not the case within school nursing.

Leadership of this service

- School nursing staff reported that managers were not visible and felt there was a lack of managerial awareness of what work school nurses undertake.
- Staff within health visiting were very clear about the management structure within the service and felt the team leaders were very visible and approachable.
- Daily management of the various teams was delegated to appropriately qualified staff in each speciality at band six or seven to ensure locally visible leadership.

Culture within this service

- There was a culture of openness and flexibility among the teams we visited. Staff spoke positively about the service they provided for children, young people and their families.
- Good team working was evident within each of the bases visited.
- Teams were not always located together in the same building, but staff morale within the different teams overall was good. Teams applied a multi-agency approach to working with other organisations such as the local authority so children and young people received the most appropriate care and treatment.

Public engagement

- In the speech and language therapy service, parents were asked to complete an evaluation questionnaire at the start and at the end of each group session. This identified any improvements made within the sessions.
- The speech and language therapy service gave an example of how feedback from parents had been used to help develop the service. This involved parents asking if they could be accompanied to the group sessions by a member of staff from the child's pre-school or nursery setting.
- Within the health visiting service, evaluation was received and reviewed for the 'baby matters' group when the service was looking at re-commissioning the service. The overall feedback for this was very positive.

Staff engagement

- Staff received communications from an organisational level such as newsletters and attended team meetings. Overall staff felt they were listened to and felt

Requires improvement

Are services well-led?

supported. However, there was some inconsistency and variability in communication with staff, which meant some staff did not feel well engaged with senior managers, particularly within school nursing.

Innovation, improvement and sustainability

- Practice innovation and improvement were limited due to organisational change, capacity issues and the volume of safeguarding work undertaken, particularly in school nursing.
- One health visitor was a fellow of the Institute of health visiting. The Institute of health visiting is a UK Centre of Excellence supporting the development of universally high-quality health visiting practice. It was launched on 28th of November 2012 to promote excellence in health visiting practice to benefit all children, families and communities. This ensured the service could benchmark against national good practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not maintain accurate, complete and contemporaneous records in respect of each service user. Records were not accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. There was both a paper and electronic record for the majority of children in the service; however, there was no summary within the electronic record to identify historic concerns or issues. We also found that there was no reference in either paper or electronic records to alert professionals that there was another set of records for the child. It was identified that it would take a minimum of four hours for staff to retrieve archived paper records. Managers were not able to give assurance that, staff would be able to identify historic concerns written in paper records and share the information with the relevant services in a timely manner. Safeguarding alerts could not be removed from the electronic record system which meant the system could not be kept accurate with current concerns. Regulation 17 (2) (c).

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Risks associated with record keeping within the children and young people's service were not appropriately managed. The risks were not on the departmental risk register and no plans were in place to complete a risk assessment prior to the records being archived.

This section is primarily information for the provider

Requirement notices

Managers were aware that alerts could not be removed from the electronic records system but no risk assessment had been completed. This had also not been put on the risk register.

Regular record keeping audits were undertaken but these did not look at key areas of concern specific to the children's and young people's service. These audits did not identify whether the child had an additional set of records or whether there was clear identification in the paper records to alert the professional that this record had transferred to electronic records. Managers were aware of this but nothing had been put in place to address it.