County Durham and Darlington NHS Foundation Trust

RXP

Community health services for children, young people and families

Quality Report

Tel: 01325 830100
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Date of inspection visit: 4-6 February 2015
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXP83	Dr Piper House		
RXPCP	University Hospital North Durham	Seaham Hub	
RXPCP	University Hospital North Durham	Stanley Children's Centre	
RXPCP	University Hospital North Durham	Crook Health Centre	
RXPCP	University Hospital North Durham	Spennymoor Health Centre	
RXPCP	University Hospital North Durham	Brandon Children's Centre	

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

There were systems in place for reporting and investigating incidents involving children and families. Systems were in place, through the integrated governance reporting system, to identify themes and to learn and share the learning from incidents. Incident reporting was increasing and support was available for practitioners who reported incidents. There was a good understanding of infection control procedures and we saw that staff used hand hygiene gels during two immunisation sessions we attended. Similarly, there was good knowledge of how to keep medicines safe in schools and children centres. Health visitor caseloads were within an acceptable range and met Lord Laming (2009) recommendations. There was one risk identified in relation to raising the level of safeguarding training required to Level two for clinicians. There was an action plan that set out the timescale for this change and a targeted approach.

The Healthy Child Programme was delivered to children and young people and initiatives such as UNICEF baby friendly were in operation. Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence-based guidance. For example, the trust had a Family Nurse Partnership team. Staff worked to deliver assessment and treatment in accordance with standards and evidence-based guidance. There was some monitoring of outcomes for patients and plans were in hand to redesign and restructure the services to make better use of resources and improve effectiveness. Multidisciplinary team working was effective. Staff were competent and working well as an integrated team in the interests of patients. Staff development, supervision and performance appraisal were in place and compliance was good.

Overall we rated children's and young people's services good for the quality of care. In all the services we visited we staff were providing compassionate and sensitive care. Children and families were encouraged to be involved in their care. Patients we spoke with, and their families, felt that they were treated with dignity and respect.

We found that the services were planned and delivered to meet the needs of children and their families. Structures had been redesigned in response to the people's changing needs and the need to manage resources between 'universal' and 'targeted' services. We found that there was good access to translation services and an understanding of the need to respond to cultural differences in the area. There was an open and transparent approach to complaints and they were treated as an opportunity for shared learning and service improvement.

There was a clear vision and strategy where the priorities of the trust were understood locally. Staff working in community children's services were committed to their work and understood the priorities of the service and their individual teams. The integration of community services into the trust was ongoing. There was strong support for the local leadership and staff appreciated the high levels of honest communication and new drive for quality.

Summary of findings

Background to the service

Children and young people under the age of 20 make up 23.9% of the population of Durham and Darlington. The health and well-being of children in Darlington is generally worse than the England average. The level of child poverty is similar to the England average with 21.3% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average. A higher than average proportion of children are judged to have achieved a good level of development at the end of the foundation stage, with 67.1% achieving this milestone.

Community health services for children, young people and families included a range of services delivered in the County Durham and Darlington area. Core services included health visiting, school nursing and Occupational Therapy and Physiotherapy services (Speech and Language therapy services are provided from a neighbouring Trust). Delivery and coordination of specialist or enhanced care and treatment, included specialist nursing services and community paediatric services. These services provided and coordinated care and treatment for children and young people with long-term conditions, disabilities, multiple or complex needs and children and families in vulnerable circumstances.

Our inspection team

Our inspection team was led by:

Chair: Iqbal Singh, Consultant Physician in Medicine for Older People.

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: doctors, nurses, therapists, a health visitor, school nurse, district nurses, community matrons, a GP and experts by experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 4 to 6 February 2015.

We held listening events on 26 January and 2 February 2015 in Darlington and Durham to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Summary of findings

What people who use the provider say

People spoke very positively about the service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should:

- Ensure that all clinicians have the appropriate level of children safeguarding training.

County Durham and Darlington NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

There were systems in place for reporting and investigating incidents involving children and families.

Systems were in place, through the integrated governance reporting system, to identify themes and to learn and share the learning from incidents. Incident reporting was increasing and support was available for practitioners who reported incidents.

There was a good understanding of infection control procedures and we saw that staff used hand hygiene gels during two immunisation sessions we attended. Similarly, there was good knowledge of how to keep medicines safe in schools and children centres.

Health visitor caseloads were within an acceptable range and met Lord Laming (2009) recommendations.

There was one risk identified in relation to raising the level of safeguarding training required to Level two for clinicians. There was an action plan that set out the timescale for this change and a targeted approach.

The service and many partners' organisations were using the same electronic record system. This was helpful in recording and sharing information in a timely way. The service was looking to extend the use of the electronic system to improve efficiency and to facilitate the remote and mobile workforce in the community.

Detailed findings

Incidents, reporting and learning

- The head of children and families services told us that since the health visiting and school nursing services had been returned to single line management by the Trust, (from the previous arrangement where services were

managed by the local authorities) the service had benefited from the strengthened clinical governance framework provided by the Care Closer to Home Care Group.

- The number of incidents reported in the care group for quarter 2, July to September 2014, had increased by 6% of the previous quarter.
- The head of community child health services informed us that the service reported about two serious incidents a month, via the 'Safeguard' electronic reporting system. All the clinical leads received a copy of the incidents and complaints and there were regular meetings to discuss issues and any themes emerging. All serious incidents were investigated and learning was shared across the service in meetings and in writing, via a services bulletin.
- An integrated governance report was prepared quarterly for the care closer to home care group. The report provided an analysis of incidents, complaints, claims, risks and compliments. The head of community child health services informed us that the report was discussed in management meetings across the service.
- We spoke with a locality manager who said, "The Safeguard system is used to log all significant events. Staff input the data and line manager oversees the investigation and resolution.." They also told us that the line manager receives a monthly alert, with any outstanding tasks on the system. This allowed managers to monitor compliance and discuss any performance issues with staff in a timely way.
- We saw copies of minutes for the health visitors and school nurses management assurance groups, where incidents were discussed and learning shared. A recent incident had been discussed and involved a family newly arrived into the country where there had been some confusion over the number of vaccinations the children had received for meningitis. Weekly meetings with frontline staff and team representatives were to begin shortly to discuss incidents and organisational governance.
- We saw a copy of the integrated governance reports for October 2014, which reported on the period between April to June 2014, in this period, there had been 541incidents reported in children and families services. The vast majority of these incidents were recorded as involving 'no harm' or only 'minor harm' to patients and most involved administration, recording and communication errors. For example, we were informed that, following migration of electronic records at one medical practice, anomalies had been found in the vaccination history. The records were being checked for errors at other sites.
- A school nurse told us about a recent incident that involved a faulty fridge and out of range temperature. In this case, the nurse said that the vaccines had to be destroyed and the fridge replaced. The incident was logged and shared.
- In all cases, we saw that the trust was learning lessons from the incidents that were reported and was changing systems where appropriate. Incidents were captured and analysed in the quarterly integrated governance reports and discussed at management, clinical governance and patient safety meetings. Notes from these meetings were circulated so that lessons were shared.
- A presentation was provided by the deputy head of child health at each of the quarterly governance meetings giving an overview of complaints, incidents and comments cards. At the meeting in October 2014, several of the 23 incidents reported in September were discussed. One issue referred to a discharge letter having not been received by the health visitor requesting a child's head circumference was to be measured twice weekly for a month. This was to be investigated and an update provided for the next meeting.
- Arising from a complaint, the governance meeting in October 2014 highlighted an inconsistency in allowing parents to be present during safeguarding investigations. In addition, it was noted that there was no written information available for parents and carers in relation to the process of care during safeguarding investigations. As a result of this complaint, a new plan was being devised involving a risk assessment in each case and the development of a range of information leaflets for parents. These plans were going to be discussed and shared in clinical governance sessions across all other relevant departments.
- The clinical lead for health visiting said that incidents were reported and taken seriously. For example, a recent incident involved a father, recently released from

prison, making threats towards a health visitor. The health visitor was moved to an alternative base and the police were alerted. The clinical lead said, "We take action if there is a threat or a risk, we are very careful." Another health visitor commented on that case and said, "Through incident reporting we were all made aware of an aggressive and threatening partner. The system works well and the information is shared."

- In addition, a father had complained about their daughter being taken out of a lesson at school to see a school nurse who was following up a safeguarding referral. This complaint led to the development of a new protocol for this type of situation and processes for obtaining parental consent.
- One specialist nurse we spoke with said that they had reported an incident over Christmas and they had a list of numbers to call to get support. They said that peers were always available to offer support.

Cleanliness, infection control and hygiene

- There were policies and procedures for infection prevention and control. Staff reported they had received infection control training and we saw information which confirmed this. Health centres and clinics we visited appeared visibly clean.
- At the two immunisation sessions we attended we saw evidence of good infection control procedures. Nurses were using hand hygiene gels. Posters explaining the hand washing process were displayed at Seaham Hub and several of the children's centres we visited.
- We observed good infection control in a clinic in Stanley Children's Centre. We saw thorough hand washing and the equipment, scales and baby mats were cleaned between clients with disinfectant wipes.
- In the six month period from April to September 2014, the integrated governance report indicated that there had been no cases of Clostridium difficile (C. Difficile) and just one case of MRSA in the care closer to home care group.

Maintenance of environment and equipment

- Since the local authorities had decommissioned the health promotion library services , arrangements were in place to distribute the remaining health promotional resource materials throughout the service. The health visiting and school nursing service used digital and web based health promotion literature for parents and young people wherever appropriate.

Medicines management

- We found there was 100% compliance with training in medicines management in children's and families services.
- We observed the cold chain process during two immunisation sessions at a school and at a children's centre. The process at the children's centre included the completion of rotas for fridge temperatures. We saw that the vaccines were checked in and out of the fridge. Batch numbers and expiry dates were recorded and running totals were kept. If a vaccine was returned, it was marked and the nurse explained that marked medicines had to be used first next time as they could only be returned to the fridge once. If they were not used, they were put into the sharps bin and then incinerated. We found there was a file with these procedures in on top of the fridge so staff had access to them.
- Staff told us that as part of ensuring safety adrenalin was available in case there was an adverse reaction to the vaccine.

Safeguarding

- All the staff we spoke with said there was good support for safeguarding. Health visitors told us, "We can always contact safeguarding support to discuss a vulnerable family." We saw that the managers were actively managing the caseload to distribute the number of families with child protection plans amongst the team.
- The Safeguarding Children and Young people: roles and competencies for health care staff Intercollegiate document March 2014 stated all clinical staff such as health visitors, school nurses and paediatric allied health professionals require level three safeguarding training.
- We saw the risk register for children's safeguarding. There was one risk identified in relation to raising the level of safeguarding training required to Level two for clinicians. There was an action plan that set out the timescale for this change and a targeted approach.

Good

Are services safe?

- The Multi-Agency Safeguarding Hub (MASH) had been established in Darlington and staff said it was working well. A similar arrangement would be established in Durham in March.
- We saw that there were alerts on the electronic record system indicating that there was a child protection plan in place.

Mandatory training

- We reviewed information from the trust on mandatory training in children's services for the end of 2014. These revealed high levels of compliance, including 100% attendance for medicines management and 93% both for hand hygiene training and safeguarding level 1.
- Compliance with essential training for the care group overall was at 96.67% for the second quarter of 2014/2015 and reported in the integrated governance report for January 2015.
- Staff told us courses were available and easy to get on to. Sometimes there was a wait if there wasn't enough places. The trust put on quite a lot of useful courses and frontline leadership courses were available.

Records systems and management

- The service used an electronic records system. We were informed that this system was used by health visitors, school nurses, the family nurse partnership, urgent care, continuing care, occupational therapy, district nurses, podiatry, physiotherapy, 60% of GPs and the looked after children's team. The head of children's services said that most of the local GPs used the same system and so they could share records. The nurses and therapists we spoke with were generally happy with the system and they found it assisted them to share information.
- Some staff within school nursing expressed frustration at not being able to address SystmOne from all the schools.
- The Safeguarding Children Annual Report for 2013/2014 commented on how SystmOne was being developed as an information management system for the safeguarding team. The report said, "This will increase efficiency within the team allowing enhanced information exchange at an operational level."
- We looked at one care record and saw the record was recorded in chronological order with standardised care plans and significant events were noted. Paper files were kept for safeguarding paperwork, including: referrals, police letters and case conference minutes. Paper records were stored in a locked filing cabinet in the health visitor's office.
- We looked at a further three records at Spennymoor Health Centre. We saw that there was multi-agency involvement in all and one involved safeguarding issues. All were well recorded with good evidence of contemporaneous timely entries.
- Records were audited once a month in the family nurse partnership to ensure that information was present on consent, significant events and outstanding issues.
- We observed the parent held child health 'red book' was used effectively at the well-baby clinics. We saw staff used the book and to explain the centile chart and the growth charts to parents.
- We were informed by several managers, nurses and health visitors that there were plans within the service to extend the capacity for mobile working and inputting data into the electronic record system without returning to an office base.
- Staff we spoke with said that record keeping could be a challenge because of the length of time it took to complete the electronic records. We observed staff after clinic recording observations and advice given to parents on the electronic record system.

Lone and remote working

- We spoke with staff about lone working. They told us that they used the 'Skyguard' lone worker system and that they felt "well protected". One nurse said, "We log in every time we do a home visit and again when we leave. If we have not logged out, a text message is sent. If we still don't respond Skyguard contacts the office and we have five minutes to respond before it is escalated."
- The nurses said that sometimes there was a problem if there was no signal and it would be logged as an incident.
- Staff told us they would risk assess home visits and if there was an increase risk they would visit in pairs or at an alternative venue.

Good

Are services safe?

- Some of the teams we spoke with told us they were currently using paper diaries, but had plans to move onto electronic diaries in line with greater mobile working.

Assessing and responding to patient risk

- We reviewed the risk register for a care closer to home care group and for children's safeguarding. Risks were identified for the services and categorised according to severity and impact. We saw that controls were in place and action plans developed and that implementation was monitored through the governance structure.

Staffing levels and caseload

Health Visiting

- In 2011 the health visitor implementation plan (DH) identified the government's commitment to increase the number of health visitor's nationally by 4,200, to be reached by March 2015. This meant for this trust there would be an increase to 179.5 whole time equivalent (WTE) health visitors by March 2015 working in the trust. The head of children and families services informed us the trust was on track to recruit up to the target number of health visitors by the end of the financial year. At the time of inspection we found there were 168 Health Visitors in post.
- Staff we spoke with indicated that caseloads were manageable, although there were some gaps and inequality in the services. Gaps included provision for enuresis services and some of the therapy services were overstretched. Child physiotherapy services have experienced a dramatic increase in referrals for muscular skeletal problems and orthotic provision.
- Lord Laming (2009) in his report on the protection of children in England stated health visitor caseloads should be no more than 400 children. The community practitioner and health visitor association (CPHVA 2009) made further recommendations that 400 should be a maximum caseload and 250 was the ideal caseload number for any health visitor.
- We spoke with the clinical lead for health visiting and they told us that each health visitor had a caseload of approximately 200 families. If a health visitor was on leave then the caseload would be covered by colleagues. In addition the head of child health told us the caseload management tool was used to 'weight' the caseload cases according to complexity and deprivation and the local capacity planning aims to ensure health visitors have a maximum of 250 (wte).
- Information provided by the trust showed that the average health visitor caseload was 208.
- Managers within the health visiting service told us they had used flexible approaches to recruitment which included staff that had retired and returned to practice within health visiting. Health visitors who retired and return were offered permanent contracts and some of these staff were now nearing retirement
- One health visiting team told us, "There is never enough time – there is always more to do." They said, "We offer a comprehensive service, but we always want to make contact with more vulnerable children and their mums." They said they completed four to six visits a day, depending on the travelling time in-between.
- Each of the health visitors would have two to four families with a child protection plan. This was monitored by the clinical lead and any that exceeded five families would be reallocated. In addition, if a caseload included a number of individuals on the teenage pathway, this would be considered as well and there was regular liaison with the family nurse partnership to help distribute the workload.
- The clinical lead for health visiting said, "It is a question of continually balancing the capacity and demand. We try and make sure that every caseload is achievable. We have mechanisms for advising when demand increases – new housing being built, for example. Staff from one area would then be moved to take up the slack in a less well-served area."
- Clinical leads told us that vacant caseloads were managed and shared. They said that they used 'screeners', band 3 support workers, where the workload was highest. One health visitor said, "The skills mix is very much appreciated – it is a great resource and we are all very well trained."
- Health visitors told us they had a weekly meeting to allocate cases. Since the new single assessment process had been adopted, the number of children with a child protection plan had fallen but the number on the lower levels of protection had increased. They felt that the new processes were helping them to manage the caseload more effectively.

Good

Are services safe?

School Nursing

- In 2004 the Department of Health (DH) in their white paper Choosing health: making health choices easier committed to the provision of 'at least one full time, year round, qualified school nurse for each secondary school and its cluster of primary schools' (school pyramids).The CPHVA (2013) further recommended there should be one full time public health qualified school nurse (SCPHN) for every secondary school and its cluster of primaries with additional qualified school nurses or community staff nurses according to health need.
- School nurses at several locations told us that they felt they were being pulled in several different directions and that this was impacting on the delivery of services. One school nurse told us, "I have a caseload of 2000 and can do very few home visits and [have] no capacity for one-to-one family support. We need to be clearer about what we want school nurses to be doing."
- The head of the service confirmed that school nursing was under pressure and this was partly due to the fact that, unlike for health visiting, there was no national specification for the service. There was also some local debate about school nursing becoming part of the local authority public health workforce.
- Following the inspection the Trust provided information which showed the number of staff employed within the school nursing service and we saw across the service there were 2.2wte vacancies at band 6 at Specialist Public Health Community Nurse school nurse level.

Family Nurse partnership

- We spoke with five family nurses working as part of the family nurse partnership for expectant and teenage mothers aged 19 or younger. This was a programme delivered under a licence and so each member of the team had a capped caseload of no more than the 25 clients. In practice, and to allow for travel and the complexity of the safeguarding issues, the family nurses had a caseload of between 21 and 24 clients. These workloads allowed the family nurses to work intensively with their clients and allowed the practitioners time for individual supervision and team meetings.

Managing anticipated risks

- Staff were reminded about the 'severe weather' policy during our visit. The nursery nurses said that there was no pressure to put themselves at risk during bad weather and they were advised to attend the nearest base. Also they said that, if the weather appeared to be getting worse during the day, they were advised to leave for home early.
- We were told by the nursery nurses, health visitors and school nurses that all new home visits were risk assessed.

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

Overall children's and young people's services were rated good for providing effective services. The Healthy Child Programme was delivered to children and young people and initiatives such as UNICEF baby friendly were in operation.

Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence-based guidance. For example, the trust had a Family Nurse Partnership team.

Staff worked to deliver assessment and treatment in accordance with standards and evidence-based guidance. There was some monitoring of outcomes for patients and plans were in hand to redesign and restructure the services to make better use of resources and improve effectiveness.

Multidisciplinary team working was effective. Staff were competent and working well as an integrated team in the interests of patients. Staff development, supervision and performance appraisal were in place and compliance was good.

Detailed findings

Evidence-based care and treatment

- The Healthy Child programme (HCP) was an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices. We found the trust monitored their performance against key contacts within the programme. For example we saw information from April 2014 to the time of inspection for the number of new birth visits undertaken between 10-14 days.
- Initiatives such as UNICEF baby friendly were in operation. The UK Baby Friendly Initiative was based on a global accreditation programme of UNICEF and the World Health Organisation. It was designed to support breastfeeding and parent/ infant relationships by working with public services to improve standards of care. The health visiting and midwifery services were currently accredited to level 2 UNICEF accreditation.
- We reviewed breastfeeding data provided by the trust. We saw for Q3 at birth breast feeding rates varied between 30% to 41% against a target of 50-64%. The breastfeeding rates at 6-8 weeks also varied between 19% to 24% against the same targets.
- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence-based guidance. For example, the trust had a FNP team. The FNP programme was a voluntary health visiting programme for first-time mothers that was underpinned by internationally recognised evidence based guidelines.
- We spoke to five nurses working as part of the family nurse partnership. The service was delivered according to the terms of the licence and was based on evidence that early intervention and therapeutic relationships with teenage mums, aged 19 and younger, produced positive outcomes for the mother and child. The outcomes from this service were measured against national targets and local key performance indicators.
- In October governance meeting the results of an audit were discussed involving the prescribing practices for Buccal Midazolam (a drug for treatment of seizures in epilepsy) and its use in the community. One of the aims of this audit was to ensure everyone was prescribing correctly and according to the clinical guidance from the National Institute for Health and Care Excellence (NICE). A number of recommendations were made as a result of this audit, including that all children have a medical management plan. This was being included in the notes for wider distribution.

- We spoke with specialist nurses working on the evidence-based programme meeting the national requirements for obesity. This was a universal service offered to children in years 4 and 5. This initiative was commissioned by the local authority in the North East because this area was the second highest for obesity of year 6 children nationally. The criteria for inclusion for

the programme were set out nationally. It ran for 10 weeks and was evaluated at the beginning and the end. There was also an on-going evaluation to assess behavioural changes after six months and one year.

Approach to monitoring quality and people's outcomes

- We were told about the Clinical Quality Improvement Framework (CQIF) that was used to monitor patient outcomes.
- We spoke with a health visitor involved in delivering the Family Initiative Supporting Children's Health (FISCH) through education about healthy eating and exercise. This was an initiative delivered in schools and aimed at promoting healthy lifestyles for seven to eleven-year-old children. The health visitor we spoke with said that there had been no recent evaluations of the outcomes from the programme; the last one had been in 2006. The programme was not able to report positive outcomes. Staff told us The service had an uncertain future and the specialist weight management service was being decommissioned. This meant there would be no specialist services available and children would be referred to the GP.
- We saw information which showed the school nursing service monitored their key performance indicators for height and weight measurements for the national childhood measurement programme (NCMP) and for the delivery of school age immunisations. For example we saw in the Durham area 74.6% of eligible children in reception class had been measured.
- We were informed that the leads and locality managers had a monthly quality meeting with the head of community child health services to discuss performance. They said that previously it had been as robust and now there was a greater emphasis on outcomes.
- We saw the operational performance report for health visiting with a description of the goal and performance against a baseline standard. We saw that all were below the target for each quarter for 2014/2015.

Competent staff

- Staff told us there was continuing professional study days across health visiting and school nursing. All the staff we spoke with reported regular monthly supervision. Restorative supervision is provided over and above clinical supervision and performance management. It is entirely voluntary and available for all staff. Staff had appraisals and rates were high for staff in this service.
- We spoke to a student health visitor who said that the trust induction was two and a half days and in the first two weeks they were taken around to see the service. They said that induction was positive and was followed up with mandatory training. Some staff informed us the arrangements for preceptorship were good.
- Community nursing staff at the focus groups said that the training was often very "acute focussed". For example, one nurse said: "Basic life support and resuscitation training was so hospital based, community was covered by just five minutes at the end." Similarly, a health visitor said that the fire training was all about "evacuating a ward".

Multidisciplinary working and coordination of care pathways

- Managers we spoke with individually and colleagues in the focus groups reflected on the integrated single line management arrangements that had been introduced recently. One health visitor said that: "[They] went into a multidisciplinary social care team and this move took me away from the other health visitors and school nurses. It was difficult to achieve key performance indicators with health, as well as the social care performance indicators."
- One of the specialist health visitors for continuing care we spoke with said there was an effective multidisciplinary team who "wrap around children and their families". They had immediate access to social workers who attend the "team around the family" meetings. They said that social workers and specialist health visitors carry out the assessment together.
- Health visitors told us that they were invited to attend the child development centre multidisciplinary team meetings to support children and young people with long-term conditions.

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Good

Are services caring?

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

Summary

Overall we rated children's and young people's services good for the quality of care. In all the services we visited we staff were providing compassionate and sensitive care. Children and families were encouraged to be involved in their care. Patients we spoke with, and their families, felt that they were treated with dignity and respect.

Detailed findings

Compassionate care

- At well-baby clinic at the Brandon Children's Centre we observed sensitive and compassionate care. We saw staff treated people with dignity and respect.
- One mother said the service was "brilliant and caring". Another mother said, "I am a single mum and they helped me with my relationship with my partner."
- We observed a health visitor with a new mother in the clinic giving reassurance about feeding in a calm and caring manner.
- We observed an antenatal home visit with a health visitor. We saw that the practitioner was very caring and responsive to the patient's needs.

Dignity and respect

- We saw school nurses offered dignity and respect to young people at the two immunisation sessions we attended. Arrangements were made for anyone who was phobic of needles. Screens were used for anyone needing to remove clothing or who became unwell.

Patient understanding and involvement

- Nurses informed us that the CQUIF returns were a valuable source of patient feedback. They received 20 to 30 questionnaires from patients each month.
- In March 2014, the integrated governance report for the care closer to the home care group said, "Implementation of the Clinical Quality Improvement Framework (CQUIF)… has provided staff with the opportunity to have quality conversations with patients in relation to fundamental aspects of care." As analysis of the patients' comments concluded by saying, "Patients note that they feel listened to and involved in decision making…staff ensure that patients, family and carers are involved in decisions relating to care and treatment."

Emotional support

- One mother told us, "They give good advice. We can get hold of the health visitor at any time and I have three numbers. They help me with breastfeeding and it is a good supportive service."
- Another mother said that she came to the baby massage sessions and enjoyed it.

Promotion of self-care

- We attended an antenatal visit and saw how the health visitor anticipated the needs of the new mother in preparation for the new baby. The health visitor talked about bonding and attachment and gave the expectant mother information, leaflets and trusted website addresses so that she could do further research.
- Health visitors gave information about promoting personal safety and self-care. This included diet, exercise, sleep and security.
- We visited a young mother with a nurse from the family nurse partnership team. In the visit we observed we saw how the young mother was encouraged to think through and answer some of the questions she was asking and had asked before. She was also given strategies for avoiding unnecessary anxiety and for remaining calm in stressful situations with a partner.

Good

Are services responsive to people's needs?

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

Summary

Overall we rated children's and young people's services as good for providing responsive services. We found that the services were planned and delivered to meet the needs of children and their families. Structures had been redesigned in response to the people's changing needs and the need to manage resources between 'universal' and 'targeted' services.

We found that there was good access to translation services and an understanding of the need to respond to cultural differences in the area. There was an open and transparent approach to complaints and they were treated as an opportunity for shared learning and service improvement.

Detailed findings

Service planning and delivery to meet the needs of different people

- We were provided with the care planning process for health visitors. This was based on care plans where the activities in the care plan were divided into four levels. Level 2 activities might include feeding advice and level 4 would involve safeguarding. The health visitors entered number of activities under each level and managers analysed the numbers of each care plan to identify trends in workload. This also helped with planning the future workload and the avoidance of HVs being overloaded in terms of numbers and demand.
- We spoke with a nursery nurse and a health visitor about a planned home visit to a family with a child with some behavioural issues in nursery.. The family had been advised to try using a star chart and the child's behaviour had improved. Staff said that they had good relationships with local nurseries and the nurseries often contacted them for advice on issues, such as toilet training and child development.
- A nursery nurse told us about a "family nurturing programme", a ten week parenting programme. We were informed that some people did not complete the course, but many completed did. Data was collected and evaluated.
- There was evidence of universal services available to all through the Healthy Child Programme and more targeted services to vulnerable groups through, for example, the family nurse partnership. There was also a teenage mother pathway for those young mothers who needed additional support, but who were not part of the family nurse partnership.
- The head of community and child health services informed us of the work the trust had been undertaking for many years to make services available to the local minority communities. The trust adopted flexible approaches to ensure that the children of travelling communities could receive immunisation and this was achieved by visiting families "on the side of the road", if necessary.
- The service was also made accessible to the Polish and Bangladeshi communities and interpreting services, though 'language solutions' were available to support this work as required. There were also interpreting services available for the school nurses.
- We visited a well-baby clinic for babies from birth to 12 months old run by early years workers and health visitors. The mothers could attend to seek advice and get their babies weighed. We were informed that similar clinics were run at different times and locations which meant there was choice of clinics for parents to attend.
- Health visiting staff told us there was a group of foreign students at the local university who were completing their studies while bringing up young families. These students and their families spoke a range of different languages and were culturally diverse. The trust had responded by setting up support groups within the university for new mothers and their babies and pre-school siblings.
- We spoke with a specialist nurse delivering services for children with complex needs. This was a service which involved nurses and therapists and integrated with colleagues from social care. The nurse we spoke with described the pathway for a 15-month-old child with continuing health needs and dysphagia (a problem with swallowing). While the pathway was clear, the nurse said there was some uncertainty about the continuing

involvement of speech and language therapy and how they would be involved since they had been transferred to a neighbouring NHS Trust. The physiotherapy and occupational therapy input was unchanged, but the nurse said: "The upheaval with speech and language [has] yet to become clear."

- Some health visitors told us about working in a deprived and a more affluent rural area. Each had challenges, including a lack of services in the more affluent areas with a risk of greater social isolation and poor public transport. While, in the deprived areas there might be poor housing, but greater access to public transport and children's centres.
- We heard at the focus group and in individual meetings with school nurses and health visitors that they had been waiting to hear about whether enuresis clinics were going to be commissioned. One school nurse said, "We have been raising this at our meetings for a long time and there is still no clarity for staff or patients." The locality manager we spoke with confirmed that the enuresis service was "not meeting the needs of service users because decisions had not been taken about: who commissions; where it was provided and who provided it." The school nursing service has addressed this issue by providing a service despite the commissioning gap and continues to work with commissioners to develop the service.
- Nurses and therapists at the focus groups said that there were "inequalities across geographical areas so that Darlington and Durham felt like different services". They said that the differences were influenced by the commissioning priorities of the local authorities.
- The continuing care service for children with complex needs was described by its manager as a "county-wide service that is equitable and defined by need".
- We spoke with the manager for occupational therapies and they said that there were still some historic arrangements for service delivery. However, the service was expanding and would be offering universal services and services in schools through teaching assistants.

Access to the right care at the right time

- With the school nurses we visited an immunisation session at a local school. We saw that the school nurses attended an assembly first to inform the students about preparing for the immunisation and making a screen available for anyone needing to remove a shirt.
- At the immunisation session at the special unit for excluded pupils we saw that nurses were using a range of strategies to engage with the young people and were offering alternatives opportunities for immunisation.
- Nursing staff throughout services raised concerns and commented on specialist services, such as weight management and enuresis fragmenting or disappearing.
- We saw that there were regular breastfeeding groups where health visitors were joined by mothers who were trained to offer peer support. The health visitor we spoke with said, "We have seen a rise in breastfeeding and it is being sustained for longer. Mothers are more aware of the support available." There was also a telephone call system to offer support to mothers.
- Health visitors provided us with a copy of the 'Early Help Strategy for Children, Young People and Families in County Durham' (2014). This had been developed with partners including the police, probation, schools/education, adult services, housing and community organisations. The aim of this strategy was to ensure it was a seamless escalation and de-escalation between services to ensure families were supported holistically by the right people at the right time.

Discharge, referral and transition arrangements

- We spoke with the continuing care team for children with complex needs. They said that the transition for these children and their families began five years before the actual date of transition to adult services. This provided opportunities to identify health needs appropriately and was in line with current best practice guidance.
- We heard about effective links with midwifes and arrangements for transition to health visitors.
- A group of five health visitors we spoke with said they had no issues with referrals to therapies and there was good liaison with community paediatrics and maternity.

Good

Are services responsive to people's needs?

- The clinical services manager said, "We are focussing on building robust referral processes, with the family at the centre, and so that families are not dependent on professionals."
- Some concerns were expressed by nurses and health visitors about the arrangements for future referrals in therapies as the commissioning arrangements were changing. We spoke with the manager for the occupational therapy services and they said that the leadership was proactive in bidding for, and winning, tenders. The service was expanding as a result.

Complaints handling (for this service) and learning from feedback

- We found there had been 34 complaints received in the care group care closer to home for the period from July to September 2014. This was a 17% increase on the previous quarter. The themes emerging for complaints for this quarter were: nursing care and procedures, examination, assessment and investigation. A thematic action was presented and discussed at the care closer to home professional forum.
- Managers and staff said that the Clinical Quality Improvement Framework (CQUIF) process provided the opportunity for staff to discuss concerns or issues in relation to nursing care with their patients. They said that they often sat with patients and discussed the questionnaire as the patient completed it.
- The clinical lead for health visiting said that we get "very few complaints". They said that they get requests for a change of health visitor and in those circumstances a senior staff member would visit the family and try and accommodate their wishes.
- We spoke with the head of community child health services who told us about a new protocol that had been developed in response to incidents occurring in primary care. The protocol involved the response to any bruising in non-mobile babies. This protocol required that, should health visitors notice any bruising, they completed a safeguarding referral, alerted a paediatrician and stayed with the baby until the paediatrician arrived.
- The head of community child health services informed us that the adoption of this new protocol had resulted in five or six complaints from parents and the parents had the support of the patient liaison service. As a result, the new protocol was being reviewed.

Good

Are services well-led?

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

Summary

Overall we rated children's and young people's services as good for being well-led.

There was a clear vision and strategy where the priorities of the trust were understood locally. Staff working in community children's services were committed to their work and understood the priorities of the service and their individual teams.

The integration of community services into the trust was on-going. There was strong support for the local leadership and staff appreciated the high levels of honest communication and new drive for quality.

Detailed findings

Vision and strategy for this service

At one of the focus groups we asked school nurses, health visitors and therapists about the vision and strategy for the service. They said that the understood the strategy of 'Right first time, every time' and that this was supported by an ethos about 'care in assessment and delivery' and 'quality and efficiency'. However some school nurses, individually and in focus groups, said that they felt school nursing services lacked a clear service specification.

- A member of staff at the focus group said, "We are getting messages all the time – top down. There is a recognition that it needs to [be] more bottom up." Another health visitor said, "Listening and hearing what people say is important to us."
- Some staff felt the trust still put "acute issues first" and that "community was still a bit of an afterthought". They said that this was reflected in the training and the CQIF process. One health visitor we spoke with said that: "Integration is a work in progress. But I feel well supported and I like the new structures in the service."
- The head of children and families services said that the greatest challenges for the service since the health and social care reforms and an increased number of commissioners, was the risk of fragmentation of service provision. Other challenges included maintaining the public health approach of universal services and staffing capacity.

Governance, risk management and quality measurement

- We saw copies of the last six integrated governance reports for the care closer to home care group. Each report contained a useful summary dashboard for the quarter indicating any shifts in the risks and trends, including the number of incidents and complaints overall.
- We saw evidence of structures in place and operating well in children services that brought together audit, complaints and incidents. We saw that managers were identifying themes, developing action plans and sharing the lessons in safeguarding, audit, governance and education (SAGE) meetings. The head of children and families services set out the process whereby professional development issues would be raised by incidents and governance would be informed by audits, complaints, incidents and clinical (NICE) guidance.
- School nurses and health visitors at one of the focus groups said, "Governance seems to be a priority. We need to accept this and get more involved." A nursery nurse told us that: "Policies are there to help protect you and if you feel protected you can do a better job because you know that you are being backed up by the trust." This nurse said that the flexible working policy was an example of this, saying, "Staff feel supported here and not over-scrutinised."
- We saw an analysis of the quality assessment tool (QAT) for one team dated October 2014. We saw that some of the comments in the returns reflected what we had heard from staff about the "format and questions not lending themselves well to their areas of work re health visiting and school nursing". The QAT was divided to reflect the Care Quality Commission (CQC) domains and key lines of enquiry.

Good

Are services well-led?

- We saw the terms of reference and agenda papers for the health visitor and school nurse assurance group. This was a countywide group, meeting monthly, to improve the quality of health services and to promote safe practice. The agenda included items on audit, safeguarding, governance and education.

Leadership of this service

- The trust had previously implemented an integrated, single line management arrangement with the local authority. We were informed by the Head of Community Child Health Services that staff had felt that this arrangement did not provide the professional accountability that they required and the arrangements had been changed.
- We spoke to nurses and health visitors about these arrangements and the decision to revert back to a more traditional structure. One health visitor said, "I feel that the trust has listened and been supportive throughout this process. We are listened to and I feel valued by managers."
- Another member of staff told us, "We are being reshuffled and TUPED around. We know our jobs are not at risk and this is to make our work more integrated with the local authority."
- There was a new structure that had just been put in place. We were informed that there had been some delay in the consultation process. We heard from three clinical managers who told us that the management of sickness absence had improved in the past three years with a more rigorous and structured process, with clear stages and improved support from human resources professionals.
- The three clinical managers informed us that the introduction of 'restorative supervision' had helped staff in dealing with 'stress' issues. They said that no one was off work because of stress in the area.
- Overall, in individual services, such as the continuing care services for children with complex needs, we heard that there was regular group supervision, management, one-to-one supervision, weekly clinical governance meetings, open access to the team leader, good preceptorship for new staff, annual appraisal and good access to mandatory and additional training.
- A locality manager said that all staff have regular one-to-one meetings and there was effective communication through meetings, emails and links to the trust intranet. Attendance at training was monitored and appraisals were recorded.
- Leaders told us said that they felt confident and competent to deal with disciplinary issues. Any member of staff would be confident to approach the leadership of the service.
- There were ten clinical leads in the service and each of them also had thematic areas to lead. That may be, for example, the Healthy Child Programme, breastfeeding, education or safeguarding.
- We were informed that that there was a lead officer for children with learning disabilities and for their transition to adult services.

Culture within this service

- We asked the clinical lead for health visiting about the culture within the service. They said that, "We feel part of a bigger trust. We are included in everything and we get all the information."
- All the teams we spoke with said that they could approach the chief executive and the top team and board. The clinical lead for health visiting said it is: "Very patient/client centred. People put that right at the front of what they do." One member of staff said, "The trust is a good employer. We have all been here for a long time and it is a strong team ethos."

Public and staff engagement

- Health visitors said that they left comment cards with the family, but did not get many back. However, they did get good verbal feedback and thank you cards. We saw from the integrated governance report that the clinical quality improvement framework (CQIF) was still being rolled out across the community services and measures were in place to improve the response from patients using comment cards, including a review of the mechanism for distribution of the cards.
- Managers and staff were fully aware of the CQIF process and said that they found it helpful to get feedback on their care in this way. Some health visitors and nurses, in focus groups and individual interviews, said that the

Good

Are services well-led?

quality assessment tool (QAT), a questionnaire to complete with patients, was worded in a way that was more relevant for acute or hospital-based services rather than community-based services.

- We saw this debate reflected in the integrated governance reports where health visitors were reminded to "ensure that staff mark 'not applicable' response in the QAT tool correctly to ensure accurate results". Some staff told us that they felt that reflected an over-emphasis on acute services and one health visitor said, "Sometimes it feels as if we don't exist out here."
- We asked the head of child health about his issue and they said that staff had been advised to adapt the questionnaire and that to have a separate process for community services would dilute the strength of the data. We provided the opportunity for staff to discuss concerns or issues in relation to nursing care with their patients. They said that they often sat with patients and discussed the questionnaire as the patient completed it.
- We saw from the integrated governance report for the care closer to home care group that were made up of 175 compliments about the services for children and families in the period from July to September 2014 and 188 in the previous quarter. Compliments were being analysed and it was reported that a significant portion of the compliments related to care and treatment provided by professionals within speech and language, physiotherapy and podiatry services.

Innovation, improvement and sustainability

- Overall, we saw a commitment within the service to continual improvement.