Buckinghamshire Healthcare NHS Trust

RXQ

Community health services for children, young people and families

Quality Report

Buckinghamshire Healthcare NHS Trust
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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)
RXQX5	Buckinghamshire Healthcare NHS Trust		

This report describes our judgement of the quality of care provided within this core service by Buckinghamshire Healthcare NHS 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 Buckinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Buckinghamshire Healthcare NHS Trust.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall rating for this core service - **Requires Improvement**

Overall this core service was rated as 'requires improvement'. We found that community health services for children, young people and families was caring but required improvement to be safe, responsive and effective. We rated leadership as inadequate.

Our key findings

Are services safe?

- The trust's incident report system was not being used appropriately. Some staff reported to us that they were discouraged from reporting incidents. Where incidents were reported, there was evidence of action but there was not consistent learning or improvement for when things went wrong. There was no assurance that all incidents and risks were being adequately identified and managed.
- Staff we spoke with were able to recognise safeguarding concerns for children and young people and showed a good knowledge and awareness of the safeguarding processes. However, some staff within school nursing teams told us that they had been asked to participate in child protection work beyond their competencies. Information was unclear on the level of safeguarding children training staff had undertaken.
- Staff identified that budgetary constraints meant that some equipment was not available, such as clinical needles for immunisation and toys to distract children when receiving treatment.
- The trust used a mixture of electronic and paper records. Some electronic systems were not compatible and so information was not being shared effectively across services about children's care. Records did not appropriately include salient information that summarised children's health needs and family history.
- Staff were following infection control procedures but toys were not being appropriately cleaned. Trust targets for staff mandatory training were not met.
- The service was assessing risks to patients but was not responding effectively due to workload pressures. Some children with identified risks were not being seen in a timely manner or could be missed because processes were not robust.
- Staffing levels were assessed and vacancies were identified as low. However, a matrix for weighting health visiting caseloads had identified a shortfall in health visitor hours. The ratio of qualified school nurses to number of secondary schools was below that recommended by national guidance. Staff within health visiting and school nursing teams told us that they were unable to perform certain aspects of their role due to workload pressures. The family nurse partnership could only fulfil 40% of its programme because of staffing capacity
- Medicines were appropriately managed.

Are services effective?

- National and evidence based practice guidelines were used to define services. However, the guidance was not always followed for example, there were only targeted, not universal antenatal contacts by health visitors; this meant there was limited early identification of need and risk. There was not effective audit and monitoring to demonstrate patient outcomes or compliance with quality standards.
- There were a limited number policies that covered care and treatment to children and young people and practice was inconsistent. Staff did not have support to develop professional practice around national guidance and there was inconsistent care and support provided across teams.
- Staff supervision and appraisal varied and staff identify difficulties in accessing training. There were no specialist trained nurses working with children with a learning disability. Staff working with young people up to the age of 21 years with a learning disability told us they did not fully understand the Mental Capacity Act 2005.
- The trust was meeting its performance targets for postnatal care, breastfeeding and the school child measurements, but not for immunisation rates, and one year developmental reviews.

Summary of findings

- There was effective multi-disciplinary working in therapy teams but coordination of care pathways and IT arrangements to share information or liaise with other agencies, such as GP surgeries, midwives and across acute hospital care, were inconsistent. There were good arrangements for multi-disciplinary team working for looked after children.

Are services caring?

- The majority of parents told us they were treated with dignity and respect by community staff. The staff displayed an encouraging, sensitive and supportive attitude and children and young people's personal, social and cultural needs were recognised. Staff understood and respected confidentiality.
- Patients, and those close to them, were involved in their care and treatment. The staff took the time to tell children in an age appropriate manner what was going to happen and encouraged them to ask any questions about the treatment. Parents were supported to manage their own health, care and wellbeing. Parents told us they felt confident in managing their children's needs. Parents and children were supported emotionally.
- The parents we spoke with told us that the services were accessible and that staff were knowledgeable, informative and caring.

Are services responsive?

- Community children and young people's services were commissioned with indicators to monitor operational service delivery. The services were not informed by the needs of the population and not addressing the needs of different people.
- The initial assessment within 28 days for looked after children target were not met. The waiting list for the learning disability service was not meeting the 18 week waiting time target.
- Staff had had training in equality and diversity and individually took account of patient needs but services were not offered to support the needs and preferences of different people that might be based on age, gender, race or religion. There was no evidence of reasonable adjustments for people with a physical disability. Interpreter services were available but information leaflets were only printed in English.
- There was not a consistent way of logging, investigating, responding to and learning from complaints. Most staff did now the process for handling complaints. People we spoke with did not know how to make a complaint or raise concerns. Where concerns had been raised, these were not always addressed.
- Staff told us that they prioritised work with people in vulnerable circumstances and would see people at times and places convenient for the young people and parents or carers. We saw evidence of person-centred care that showed community staff were responsive to individual needs and worked flexibly with people towards improved health and wellbeing.
- Children had good access to services, and parents could attend appointments with health visitors and at child health clinics at convenient time

Are services well led?

- The trust did not have a strategy for children and young people's services. Staff did not know and understand what the vision, values and strategy were for the trust. The majority of staff told us that the services they delivered were not high on the trust agenda.
- Staff within school nursing team told us that they were discouraged or not heard when they raised concerns about being able to deliver services safely. There had been a lack of management support and staff were dissuaded and bullied if they raised concerns. The concerns included being told to take on responsibilities beyond their competencies and workload pressures leading to staff being unable to perform some of their role. A new database tool had identified risks in children but staff were unable to address these. Staff reported their concerns but these had not been acted on and these had not been escalated to the board.
- There was a process of governance and performance was monitored but many staff told us the culture was focused was on achieving performance indicators and their skills and many aspects of the preventative work were not valued.
- Some policies and pathways in community children and young people's services had been developed within teams of staff at a local level. They had not gone through a governance process and had not been ratified by the trust.
- Risks were not being identified, monitored and assessed appropriately. This was being impeded by

Summary of findings

individuals rather than processes. There were not robust lone working arrangements or an escalation process. The trust board had only recently started to engage with the service to understand what services were delivered and identify areas of concern.

- The service supported innovative practice but staff were not well resourced or given time to contribute or deliver this effectively. The service did not have plans for future improvement or sustainability, in terms of staffing, succession planning and managing finances. Most staff told us the focus of the trust was on the acute sector and that children and young people were not high on the trust agenda.
- Patient feedback was developed in therapy services and in the Family Nurse Partnership team but there were limited opportunities for people who used the service to give feedback elsewhere. .
- The Family Nurse Partnership (FNP) service had the right structures and processes and had been assessed as performing well.

Summary of findings

Background to the service

Buckinghamshire Healthcare NHS Trust is commissioned to provide a range of community health services for children, young people and families including a looked-after children and youth offending team, health visitors, school nurses, the Family Nurse Partnership (FNP), community paediatricians, an enuresis nursing service, nurses working with children with a learning disability, community physiotherapy, and community occupational therapy. Children form about 128,000 of the total population of approximately 505,000.

The trust employs 103 whole time equivalent health visitors with 28 whole time equivalent staff supporting them in their role. The school nursing service comprises 9.45 whole time equivalent qualified school nurses, with nearly 24 whole time equivalent staff supporting them. Staff supporting school nursing and health visiting include community staff nurses, nursery nurses, healthcare assistants and administrative support.

The trust employs 13.25 whole time equivalent staff in community physiotherapy and 26.16 whole time equivalent staff in occupational therapy. The looked-after children and youth offending service has 2.15 whole time equivalent staff, the FNP service has six whole time equivalent staff. The learning disability nursing team comprises 8.30 whole time equivalent staff. There are six paediatricians who undertake work in the community.

Our inspection team

Our inspection team was led by:

Chair: Mike Lambert, Consultant in Emergency Medicine, Norfolk and Norwich University Hospital

Team Leader: Joyce Frederick, Head of Hospital Inspections, Care Quality Commission (CQC)

The team of 35 included CQC inspection managers and inspectors. They were supported by specialist advisors including health visitors, a school nurse, a physiotherapist, an occupational therapist, district nurses, registered nurses, a paediatrician, a GP, a pharmacist, safeguarding leads, a palliative care consultant and palliative care nurses. Three exerts by experience who had used the service were also part of the team. The team was supported by an inspection planner and an analyst.

The team that inspected this service included inspectors, health visitors, a school nurse, a physiotherapist and a paediatrician.

Why we carried out this inspection

We inspected this core service as part of a community inspection.

Buckinghamshire Healthcare NHS Trust had a comprehensive inspection of its services in March 2014. However, its community services were not inspected at that time. We therefore completed the inspection of its community services.

How we carried out this inspection

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

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

Summary of findings

Before visiting Buckinghamshire Health NHS Trust, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out an announced visit on 25, 26, and 27 March 2015.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 10 and 11 April 2015.

For this core service we visited and spoke with staff at three health visiting bases, two school nursing bases, and the base for the learning disability and special schools support service. We visited the Family Nurse Partnership base and spoke with staff. We visited two bases for the community occupational therapists and the community physiotherapists and spoke with these staff. We also spoke with staff in prearranged focus groups and interviews and with staff opportunistically and at their request in other venues. We observed two child health clinics provided by the health visiting service, and accompanied two health visitors on visits to clients' homes. We accompanied a nurse from the learning disability team on a visit to a client's home. We observed a combined occupational therapist and physiotherapist clinic, and accompanied staff on visit to a client's home and a nursery visit. We observed an enuresis clinic. We reviewed care records for 24 children and a variety of team-specific and service-based documents and plans. We spoke with 82 staff across the services including health visitors, school nurses, a looked-after children nurse, family nurse partnership nurses, community physiotherapists, community occupational therapists, nurses from the learning disability team, administrative staff, community paediatricians, leads for safeguarding children, staff in management roles and service managers. We also spoke with two external health and social care professionals.

During our inspection we spoke with 47 parents, carers and children. We also received feedback from external partner organisations.

What people who use the provider say

The majority of parents told us they were treated with dignity and respect by community staff. They told us they felt confident in managing their children's needs. We heard comments such as, "The health visitors are really helpful and there when I need them.", and the "doctor … is brilliant all the team are available, helpful, cannot fault". Many parents commented on the service being accessible and the staff being approachable. Parents and carers told us that staff always involved them in decisions about care and treatment for their children. One parent told us that a member of staff "is always there, a lifeline…..she helps me feel in control of all the changes every day".

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust MUST ensure

- Staff are able to freely raise any concerns about being unable to deliver services safely and that this is heard and acted on by management.
- Staff use the incident reporting system to report concerns
- Staff have appropriate safeguarding and mandatory training
- Ensure there are mechanisms in place to obtain feedback from people who use services.
- Staffing levels are assessed and reviewed using an evidenced based tool and meet recommended guidelines.
- Staff can appropriate identify and respond to patient risks

Summary of findings

- All pregnant women receive a universal antenatal contact with a health visitor.
- Multi-disciplinary team working is effective and pathways of care are coordinated and, where necessary, children receive early support.
- There is an audit programme to monitor the quality and safety of services.
- Children on the learning disability waiting list are appropriately managed
- Consistently log, investigate, respond and learn from complaints in the community children and young people's services.
- Staff fully understand the Mental Capacity Act 2005 and the deprivation of liberty safeguards.
- There is a service strategy and services are planned effectively around prevention and local need.
- The leadership concerns are fully investigated and action is taken to ensure and open, transparent and supportive culture exists in the service.
- Governance arrangements are improved.
- Patient engagement and feedback is improved across the service
- Staff engagement is improved across the service.
- Budgetary constraints do not adversely affect the care and treatment of children, young people, and parents and carers.

The trust SHOULD ensure

- The use of the new database tool in school nursing is reviewed and address the concerns identified about delivering this programme.
- Staff have had the necessary training, skills, competencies and support to fulfil their roles and receive appropriate supervision and appraisal.
- There are clear trust governance and ratification process for policies and pathways in community children and young people's services.
- Staff can participate in professional practice development groups and that these contribute to the development of trust policies and pathways.
- There are robust contingency planning and escalation processes and lone working procedures.
- The trust safeguarding policy on child sexual exploitation is up to date and reflects current guidance

Buckinghamshire Healthcare NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as 'requires improvement'.

The trust's incident report system was not being used appropriately. Some staff reported to us that they were discouraged from reporting incidents. Where incidents were reported, there was evidence of action but there was not consistent learning or improvement for when things went wrong. Occupational therapists and community physiotherapists knew how to use the process and incidents were acted on. There was no assurance that all incidents and risks were being adequately identified and managed.

Staff we spoke with were able to recognise safeguarding concerns for children and young people and showed a good knowledge and awareness of the safeguarding processes. However, some staff within school nursing teams told us that they had been asked to participate in child protection work beyond their competencies.

Staff identified that budgetary constraints meant that some equipment was not available, such as clinical needles for immunisation and toys to distract children when receiving treatment.

The trust used a mixture of electronic and paper records. Some electronic systems were not compatible and so information was not being shared effectively across services about children's care. Records did not appropriately include salient information that summarised children's health needs and family history.

Staff were following infection control procedures but toys were not being appropriately cleaned. Trust targets for staff mandatory training were not met.

The service was assessing risks to patients but was not responding effectively due to workload pressures. Some children with identified risks were not being seen in a timely manner or could be missed because processes were not robust.

Requires improvement

Are services safe?

Staffing levels were assessed and vacancies were identified as low. However, a matrix for weighting health visiting caseloads had identified a shortfall in health visitor hours. The ratio of qualified school nurses to number of secondary schools was below that recommended by national guidance. Staff within health visiting and school nursing teams told us that they were unable to perform certain aspects of their role due to workload pressures. The family nurse partnership could only fulfil 40% of its programme because of staffing capacity

Medicines were appropriately managed.

Incident reporting, learning and improvement

- The use of the trust-wide electronic incident reporting system varied. Occupational therapists and community physiotherapists were able to describe how incidents had been reported and acted on. However, the majority of health visitors and school nursing staff told us they were discouraged from using the reporting system, had not received training on how to use the process and had been told to only report incidents to their line manager. Many school nurses and health visitors from certain rural and urban areas told us they had reported workload pressures and concerns about safety to their line manager. These were not reported as incidents and were not being and acted on.
- Serious case reviews and the actions being taken were reviewed by the trust board's Serious Event Committee. The trust ran drop-in sessions which were held at three of the trust's locations. This made the sessions difficult for staff to access, though they were available by video. Most staff commented that these sessions focused on incidents from the acute sector and the items covered were not relevant to community staff.
- There was one reported serious incident in community children and young people's services. This was currently being investigated. There were five reported incidents on the trust-wide incident reporting system for community children, young people and families. Four incidents were related to administrative, non-clinical incidents, and one was in relation to immunisations. Community physiotherapists and occupational therapists told us how these five incidents had been investigated and practice changed as a result. An example was of a letter being sent to the wrong address; the process for checking addresses had now been changed.

Duty of Candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred
- Staff we spoke with were aware of their responsibilities within the Duty of Candour but they did not have guidance or processes to follow this.

Safeguarding

- The acute and community sector of the trust had five named nurses for safeguarding children, plus one lead safeguarding children nurse with responsibilities for the emergency department and the multidisciplinary assessment hub, and a lead professional for child protection. There was a named midwife across the trust. There was a named doctor for child protection (acute) and a named doctor for child protection (community).
- The Royal College of Paediatrics and Child Health (RCPH) intercollegiate guidance advises that named doctors and named nurses should receive safeguarding supervision from the designated nurses in the Clinical Commissioning Group (CCG). The two named doctors did not have formal child protection supervision. Service managers told us a member of staff had been identified to take on this role temporarily.
- The trust safeguarding policy was reviewed in May 2014. The trust worked in partnership with the local safeguarding children board, participating in working groups on early support for families, improving time frames for looked-after children initial health assessments and on the identification and prevention of child sexual exploitation. This meant there was joint working to identify and protect children and young people at risk of harm.
- Guidance within the trust safeguarding policy on child sexual exploitation was dated 2009 and did not contain the national child sexual exploitation pathway published in early March 2015.
- Staff were able to recognise safeguarding concerns for children and young people and showed a good knowledge and awareness of the safeguarding

processes. However, band 5 nurses within the school nursing service told us that they had been asked to participate in child protection work beyond their competencies, for example, in undertaking assessments and contributing to child protection case conferences and plans.

- There was a system in place to ensure that health visitors or school nurses, depending on the child's age, were notified when a child or young person had attended the emergency department. However, staff told us the forms could take a week to reach their team. A health visitor or school nurse would have the responsibility to assess the forms or emails from the trust's safeguarding nurse and ensure that any required action was taken.
- All the staff we spoke with told us they were able to access safeguarding advice as required and had regular planned safeguarding supervision at time intervals depending on their role.
- Safeguarding children training at level 1 was completed by 83% of all staff across the trust. Staff at band 6 within the community children and young people's service told us that they had received level 3 safeguarding children training. However, information on staff receiving safeguarding children training at level 3 was not recorded by the trust. The level of training for all staff was below expected levels and was identified as a risk on the corporate risk register.

Medicines management

- Staff who delivered the school health immunisation programme told us protocols were in place with appropriate checks and monitoring such as daily temperature checks and vaccines logged in and out. Medicine records confirmed these actions had been taken.

Environment & equipment

- A central register of equipment was held by the trust. An audit had been undertaken over the previous 18 months to ensure that the register was current. There was an established planned preventative maintenance for all medical equipment. The system could track equipment that could not be found when maintenance or a service was due.
- The trust had taken a risk-based approach to the testing of portable electrical appliances in line with guidance. Some items would be tested annually and other items were tested at up to four year intervals.
- Several staff told us that there were budgetary constraints on equipment they needed to treat children and young people. Therapists told us there were not enough toys to use to distract children when needed. School nurses told us of being told not to retrieve needles that been allocated to hold back for budgetary reasons.
- Health visitors told us that equipment such as scales were annually checked and calibrated through the trust's maintenance programmes.
- During our inspection, at two trust sites we visited, there were incidents of equipment not working but repairs managed appropriately. There was a system in place to report any faults. For example at one location the heating had broken down. This had been reported and repairs were completed within 48 hours. Staff in the meantime had provided alternative heating.
- The clinics we visited were well lit and had enough space
- Staff were provided with mobile phones as they often worked alone in the community, this provided staff a degree of safety with them being able to contact colleagues as necessary.

Records and management

- The electronic system used by the staff working in the community was not compatible with the hospital system and other local providers. This meant that staff using the different systems were unable to access records, for example care plans. Staff told us that they liaised with colleagues directly but there was an increased risk to people using the service receiving inappropriate, unsafe care. An example of this was a child identified as being at risk of choking but this was only recorded on one system.
- We looked at eight personal child record books held by parents and used by staff working with children and we reviewed 24 electronic records. Staff spoke of having to read through all of the individual's electronic record to get a sense of the service a person was receiving. The system did not link siblings and staff told us they only added fathers 'as appropriate'. This lack of information about family history and a summary of health needs could have an adverse impact on care and treatment.

Requires improvement

Are services safe?

- Children on the health visiting team's caseload assessed as requiring an 'enhanced' service above the 'universal' service (either 'universal partnership' or 'universal partnership plus') as set out by the Healthy Child Programme, were identified. Managers of the health visiting team were able to access this. Personal laptops were provided for some health visitors but this varied across the trust. Many staff had to go to the office to access a computer.
- The new electronic health needs assessment tool introduced to the school nursing team to deliver the Healthy Child Programme was not compatible with the electronic system already in use, and staff required new computers to use this database. The school nursing service specification for 1 April 2015 stated that laptops had been funded by the commissioners for the sole use of the school nursing service. School nurses told us they were expecting new laptops for this database.

Cleanliness, infection control and hygiene

- In the clinics and sessions that we attended we observed staff using hand sanitiser between contacts with different people using the service.
- In child health clinics we observed the use of disposable paper lining for baby weighing scales and changing mats were used. Staff told us that these scales and changing mats were wiped clean and the paper changed between each baby.
- The training matrix for community children and young people showed that 82% of staff had completed their infection control training. Information on hand washing audits was not available for the community children and young service. The majority of health visitors were unaware of the World Health Organization's 'Five moments for hand hygiene'. This meant that senior managers could not be assured that all staff maintained good standards of hand hygiene.
- Services were held in a variety of locations both on the trust's and other provider's premises. Staff told us that individual staff took responsibility for cleaning toys. There was no systematic process or records to show when toys used on trust premises were last cleaned and checked.

Mandatory training

- The corporate risk register identified a below-expected completion for training with a target of 90%. The matrix we saw showed that 86% of staff within community children and young people's services had completed mandatory training, including fire safety, infection control, information governance, safeguarding adults level 1, safeguarding children level 1, summoning emergency help, health and safety, moving and handling, and equality and diversity.

Assessing and responding to patient risk

- Children using the occupational therapy, physiotherapy and enuresis services had comprehensive assessments and risks were identified. Staff here told us they were able to respond to patient risk and showed us the process used and examples of when this had happened.
- Children using the health visiting and school nursing services did not have comprehensive assessments, key opportunities for these such as an antenatal contact were often missed and risks were not always identified or addressed in a timely manner. New birth visits had minimal recorded assessments. Health visitors and school nurses were not consistently able to respond to changing risks for those using the service.
- The trust had introduced an evidenced based tool to assess the health needs of children in schools and to deliver the Healthy Child Programme. The tool was a questionnaire sent to parents to identify any health concerns and issues such as self-harm, obesity, safeguarding abuse, alcoholism, mental health and general public health. However, the service did not have the resources to meet this need. The unmet need was identified but the school nurses had been unable to respond to the number of alerts the system had generated. There had been over 900 referrals or safety alerts as a result of the questionnaire and these children were not being seen. The risk had not been escalated. This was placing children and young people at risk.
- Health visitors were not currently providing universal antenatal visits to all pregnant women as identified in the Healthy Child Programme. Staff told us that midwives identified pregnant women requiring extra support who were then offered a visit by the health visitor. Some staff told us some women with additional needs had not been identified by this process.
- Health visitors told us they used a duty system where each working day Monday to Friday one health visitor had certain set responsibilities including dealing with phone calls, correspondence and messages and responding to these according to need. This included assessing emergency department attendance forms and

reports from police of domestic violence where children were present and deciding what action needed to be taken. Staff in certain urban and rural areas told us that due to workload pressures these duty responsibilities were not always met and that sometimes these forms, reports and messages would be left for a few days or for the weekly allocation team meeting. During this meeting health visitors assessed and prioritised client's needs and those of the caseload and organised how to meet these needs. Staff were unable to say how often this occurred, and told us that no information on this was collected or reported. We saw in message books used by staff that there was no process to capture what had been reviewed and what action, if any, had been taken. This meant that the trust could not ensure that children and young people at risk of harm were identified and responded to in a timely manner.

- Referrals were made to other services when required and we saw evidence of this in client files.

Staffing levels and caseload

- The trust had identified vacancies in the school nursing service, the health visiting service, the looked-after children team, the youth offending team, the Family Nurse Partnership (FNP) service. The trust had also identified the effect of the vacant designated doctor for child protection post.
- The health visiting teams comprised experienced and newly qualified health visitors, community band 5 staff nurses, nursery nurses and an administrator. Senior managers told us the trust had achieved its planned trajectory for the recruitment of health visitors in line with the expected increase in workforce through the 'Call to action: health visitor implementation plan 2011–15'. The trust identified a 5.23 whole time equivalent vacancy in health visiting.
- There was a weighting system for health visiting caseloads. Out of the 19 health visiting teams, the matrix identified a shortfall in 14. Seven health visiting teams had a shortfall of between 23% and 47%. Health visitors spoke of having large caseloads and that were difficult to manage. Some staff told us that at times of workload pressure they were not always able to address identified needs in children and families
- The school nursing teams comprised qualified school nurses, community band 5 staff nurses, healthcare assistants and an administrator. One team had a community nursery nurse, and two school nursing teams had student school nurses placed with them. The trust identified a 0.63 whole time equivalent vacancy in school nursing.
- The school nursing teams told us that staffing was an issue. Staff were "concerned about lack of capacity and that they were a reactive service not a proactive service". National guidance from the Royal College of Nursing (RCN) recommends one qualified school nurse for each secondary school and its cluster of primary schools. The trust was not meeting this recommendation. At the time of our inspection, the trust employed 9.45 whole time equivalent qualified school nurses (a total of 12 school nurses) and there were 34 secondary schools and 181 primary schools in the trust's catchment area. School nursing staff spoke of having to prioritise children in care, child protection work, immunisations and the national child measurement programme.
- The majority of school nurses and health visitors within certain rural and urban areas had reported concerns about caseloads and workload pressures to their managers. Health visitors in these areas told us that they worked extra unpaid hours to meet the needs of the service. Out of the eight managers we spoke with, three felt under pressure with the competing demands.
- The looked-after children, youth offending team comprised the designated nurse for looked-after children, a specialist nurse and the administrator. The youth offending nurse was on annual leave before leaving. A community paediatrician had returned temporarily to undertake the initial health assessments for those children coming into the care of the local authority. The trust had identified a 3.15 whole time equivalent vacancy in this service.
- The Family Nurse Practitioner (FNP) national programme sets out that one Family Nurse has 25 clients and there are strict criteria for acceptance into programme and the visiting programme so missing practitioners would impact on fidelity of programme. The FNP service comprised an FNP supervisor (team leader), six family nurses, one administrator and one named nurse. The trust had only been able to offer this to 40% of the population who met the criteria due to staffing capacity. There was also one family nurse was on maternity leave and this post was not covered.

Requires improvement

Are services safe?

Managing anticipated risks

- Staff had diaries accessible to their colleagues and these were kept up to date. Staff liaised to ensure that anticipated work was covered during staff annual leave and training commitments**.**
- Staff we spoke with told us that in the event of staff sickness, they would cover for each other. Annual leave was coordinated to ensure there was cover for the service. Staff told us they were able to remotely access colleagues' office phones for messages. We were told that there were arrangements in place for bad weather, and that these were locally arranged.
- The Ofsted inspection of the children's services for Buckinghamshire County Council in 2014 had judged the children's services as inadequate. Care for looked-after children had been deemed inadequate. Ofsted had identified that guidance on thresholds for intervention and access to early help for families had not been clear. Health visitors, school nurses and looked-after children nurses had, as a result, been working with high levels of need. This had had an impact on what service health visitors and school nurses could provide and what the looked-after children and youth offending teams could achieve.
- Joint work streams were working to address the issues identified by Ofsted. The number of children subject to a child protection plan as of January 2015 was 352, in March 2014 this was 263.The number of looked-after children in the care of the local authority living within the county was just over 200 which was similar to the previous year . These figures would be within the expected range for a trust with this size of children and young people population. Health visitors and school nurses told us they prioritised child protection work and undertook review health assessments for looked-after children

Major incident awareness and training

- Staff told us there were informal local arrangements to respond to emergencies and major incidents and gave examples of responding to extreme weather conditions. We did not see evidence of policies or practices in responding to major incidents.

Requires improvement

Are services effective?

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

Summary

We rated effective as requires improvement.

National and evidence based practice guidelines were used to define services. However, the guidance was not always followed for example, there were only targeted, not universal antenatal contacts by health visitors; this meant there was limited early identification of need and risk. There was not effective audit and monitoring to demonstrate patient outcomes or compliance with quality standards.

There were limited number policies that covered care and treatment to children and young people and practice was inconsistent. Staff did not have support to develop professional practice around national guidance and there was inconsistent care and support provided across teams. Some health visitors spoke of the 'rules' of the electronic system guiding their practice or locally agreed policies

Staff supervision and appraisal varied and staff identify difficulties in accessing training. There were no specialist trained nurses working with children with a learning disability. Staff working with young people up to the age of 21 years with a learning disability told us they did not fully understand the Mental Capacity Act 2005.

The trust was meeting its performance targets for postnatal care, breastfeeding and the school child measurements, but not for immunisation rates, and one year developmental reviews.

There was effective multi-disciplinary working in therapy teams but coordination of care pathways and It arrangements to share information or liaise with other agencies, such as GP surgeries, midwives and across acute hospital care, were inconsistent. There were good arrangements for multi-disciplinary team working for looked after children.

Evidence based care and treatment

- The Healthy Child Programme (HCP) is the universal clinical and public health programme for children and families from pregnancy to 19 years of age with a core schedule of reviews. The Healthy Child Programme (HCP) emphasises the need for the early identification of need. The trust's health visiting performance specification for 1 April 2014 to 31 March 2015 set out what should be provided and the expected percentage to be achieved. The elements set out were a new birth visit 10–14 days postnatally, a 6-week postnatal review, and 'ages and stages' questionnaires at 1 year and 2 years of age. Staff we spoke with told us there had been, until recently, antenatal classes for first time parents with health visitor sessions. The specification did not include the universal antenatal health visitor as set out in the HCP, although it did provide the remainder of the core universal HCP.
- Both the HCP and national health visiting service specification state the importance of a universal antenatal contact by a health visitor. The trust was not providing this; it provided a targeted antenatal contact following identification by a midwife of pregnant women with additional needs. Health visitors told us that they had met women postnatally who had additional needs and required extra support but who had not been previously identified.
- Mothers at the 6 week postnatal review were asked questions to assess their emotional wellbeing and mothers identified with postnatal depression were offered listening visits by the health visitor as set out in National Institute for Health and Care Excellence (NICE) guidance. There was no perinatal mental health pathway for women presenting with severe depression or postpartum psychosis.
- New guidance and pathways to be used from 1 April 2015 were included in the new health visitor universal family offer document. The documented reflected NICE guidance and set out the proposed universal core contacts and the pathways for those requiring more support through the universal plus and universal partnership plus service. However, the document did not have specific detail or cover the breadth of the guidance.
- Health visiting staff we spoke with told us that they had received training on the Solihull Approach and used this model to support their practice. This model helps families process their anxieties so that they are able to

think about the behavioural difficulties their children show and then help their children cope with their emotions. This in turn helps the relationship between parent and child and supports the parent to work with their child's behaviour.

- Staff within health visiting, school nursing and service managers told us that staff informed themselves of relevant NICE guidance and other guidance. Managers told us that they worked on developing particular guidance in addition to their management role. An example of this was a team leader working on the start of the trust's breastfeeding UNICEF 'Baby-friendly initiative'.
- Staff in the enuresis service supported and treated children using relevant NICE guidance on the management of bedwetting.
- There was not a professional practice development group in which guidance was disseminated and discussed with staff. Some health visitors spoke of the 'rules' of the electronic system guiding their practice or 'locally agreed' policies. Staff within the same discipline described some ways of working and actions they took that differed from colleagues in other areas within the trust. In one health visiting team staff were seeing all children under school age who transferred onto the caseload. In another team staff rang the family if they had a child under the age of three years and then decided whether to see the child. This meant there was an inconsistency in practice across the trust and the trust could not be ensured what service was being provided or if it was in line with national guidance.
- Health visitors and school nurses told us they were not involved in developing policies and pathways, and that there was not a process whereby their professional views were sought.
- A project was in place in the therapy service reviewing the multi-agency pathway for children with complex disabilities. We saw in the most recent occupational therapy annual report that national guidance guided its work and developments.
- The Family Nurse Partnership Programme (FNP) had been delivered by the trust for two and a half years; this is a licensed national programme with set core elements. The FNP was offered to support first time mothers (and fathers/partners) aged 19 and under. The trust had only been able to offer this to 40% of the population who met the criteria due to staffing capacity. The programme provided an intensive set pattern of visiting and there were certain goals that need to be achieved. The first cohort of clients had just 'graduated' through the programme from early pregnancy to their child's second birthday. The annual review report commented that the team were very high performing with only one goal that hadn't been met, which was recruiting clients by 16 weeks of pregnancy.
- The looked-after children designated nurse contributed to strategic planning to improve the timeliness and quality of the health assessment process for children in the care of the local authority.

Nutrition and hydration

- Trust funding had recently been agreed to start the UNICEF 'Baby friendly initiative' to support breastfeeding, with an implementation visit arranged for the following month. The trust ran regular breastfeeding peer support groups in local facilities and a weekly breastfeeding advice clinic held in a hospital. As of March 2015 the local breastfeeding initiation rates was 76.1%; nationally it was 73.9%. The prevalence of breastfeeding at 6–8 weeks locally was 54.3%; nationally it was 47.2%.
- Health visitor clinics were available across the trust where babies were weighed and measured. Parents could access advice on feeding and nutrition.

Approach to monitoring quality and people's outcomes

- The managers and staff were able to tell us and show us which key performance indicators were being monitored in their service and how they were progressing in meeting the targets.
- Information on the targets set by the trust for the health visiting service showed that the percentage set for babies receiving a face to face contact between 10 and 14 days postnatally by a health visitor had been increased. The trust achieved 60% at the end of June 2014 (the target was 40%) and achieved 86% at the end of December 2014 (the target was 75%).
- The targets for babies being breastfed at 6–8 weeks had also been achieved. The trust achieved 55% at the end of June 2014 (with a target of 38%) and 59% at the end of December 2014 (with a target of 46%). The target for the one year development review had not been reached. By the end of June 2014 28.8% of children had a 1 year review with a target of 45%, measured again at 15 months and 80% had had this development review.

By end of December 2014 39% had a 1 year review with a target of 70%, measured again at 15 months 70% had had this review (these later figures include the initial measurement).

- Data on the targets and the percentages achieved by the school nursing service in delivering immunisations and the national child measurement programme was available. This showed targets for the immunisation rates had been almost been reached while the national child measurement programme had achieved. By the end of June 2014, 94% of children in reception class had been measured (with a target of 90%) and 92% of the children in year 6 had been measured (against a target of 80%). The target for Meningitis C immunisation was 95% and 89% was achieved by end of June 2014.
- There were outcomes and pathways in place in therapy services to monitor care.
- Staff told that audits were planned in the community children and young people's service but at the time of our inspection, there were no results from audits.

Competent staff

- There was a preceptorship programme with set meetings and guidance in place to support newly qualified health visitors and school nurses. Recently qualified staff told us that they felt well supported.
- Staff told us that there was inconsistency in the support available to them for appraisal and supervision. The corporate risk register identified a below-expected number of appraisals. Appraisal figures for nursing staff within the service division of women and children where community children and young people were aligned was 88%. Allied health professionals within this service division achieved an appraisal rate of 95%. Supervision varied as some staff had received peer reviews, some had regular group management supervision and some requested supervision ad hoc.
- Some staff spoke of difficulty in accessing online learning and any training longer than two days. The local safeguarding children board had identified that staff working with children required further training to work effectively, based on recent research and developments.
- There were no specialist trained nurses working with children with a learning disability. Staff working with young people up to the age of 21 years with a learning disability told us they did not fully understand the Mental Capacity Act 2005.
- Many staff told us that grading did not reflect work and responsibilities; for example there were staff working in a modern matron, nurse consultant capacity but graded at a lower band.

Multi-disciplinary working and coordination of care pathways

- We observed good multidisciplinary working and pathways in the therapy services with combined occupational therapy, community physiotherapist, and speech and language therapy clinics.
- Staff told us there were sometimes difficulty in accessing and being able to talk to social workers about families they were both supporting.
- The health visitors told us that each surgery and children's centre had a health visitor linked to that service. However, process to share information or liaison with other agencies, such as GP surgeries and midwives, were inconsistent. Some staff told us they attended monthly surgery meetings, or checked a message book at the surgery. Some staff met the midwife regularly, others received forms. Health visitors told us there had been times when GPs had not liaised with them about individuals; an example of this was not being informed of mothers identified with postnatal depression by the GP when these mothers required extra support.
- Some staff told us there was a gap in provision for those children and families requiring early intervention and secondary prevention to help families as soon as problems begin to stop problems getting worse or escalations to child protection. Currently there was not a forum for multidisciplinary working and coordination for this level of support. Staff told us they were signposting people to activities or referring people to single agencies.
- Some health visitors told us that there were difficulties in having a coordinated approach if a child received treatment in a hospital in a neighbouring trust. Examples of this were difficulties in accessing a community paediatric nurse for children requiring nursing support who were under the care of a paediatrician employed in another neighbouring trust, and delays in receiving emergency department attendance forms.
- The looked-after children nurse had a laptop that enabled access to the children's services database of

children in care and was involved in regular multidisciplinary meetings. This meant that care and support for looked-after children from health and children's services was integrated.

Referral, transfer, discharge and transition

- The trust used a multiagency transitions protocol and pathway in the community nurses service that worked with children with a learning disability. The physiotherapy and occupational therapy services used referral criteria and clear multidisciplinary pathways.
- The daily duty system used by health visitors included monitoring and acting on individuals joining and transferring out of the caseload. Staff in some areas told us they were sometimes unable to fulfil this duty system each day. Staff told us they offered face to face appointments to those from outside the trust's area and written information with the offer of a telephone contact to those moving into the area. There were mixed responses about the time frame set for these contacts. This meant that there was the possibility that children and families needing additional support would not receive timely support from the service.
- There was a protocol for the follow up of children who did not attend clinic appointments. Informing the health visitor was not included in this protocol. Government guidance 'Working together to safeguard children' highlights the importance of information sharing to protect children from harm.

Availability of information

- Not all staff had laptops to access information remotely. Some health visitors had laptops, others had to use the office. It was being planned for school nursing staff to have laptops from 1 April 2015.
- The electronic systems used by the community children and young people's service were not compatible with the hospital system, systems for other local providers and the new database tool. This meant that staff using the different systems were unable to access records, for example care plans.
- There was a trust-wide intranet, which was where the trust's up-to-date policies and procedures were kept. There was limited information for policies related to community children and young people and these had not been ratified. This meant that the trust could not be assured that staff were providing safe effective care through the use of clear ratified policies and procedures.

Consent

- Staff told us they obtained children's, young people's and families' consent before starting treatment. They were aware of the assessment of competency using the Gillick guidelines for children and young people. This framework was used when deciding whether a child or young person was mature enough to make decisions without parental consent.
- Staff working with young people up to the age of 21 years with a learning disability told us they did not fully understand the Mental Capacity Act 2005. This meant that the service could not ensure that where people may lack the mental capacity to make a decision, that decision could be made in the person's best interests.
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Requires improvement

Are services effective?

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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

We rated caring as good.

The majority of parents told us they were treated with dignity and respect by community staff. The staff displayed an encouraging, sensitive and supportive attitude and children and young people's personal, social and cultural needs were recognised. Staff understood and respected confidentiality.

Patients, and those close to them, were involved in their care and treatment. The staff took the time to tell children in an age appropriate manner what was going to happen and encouraged them to ask any questions about the treatment. Parents were supported to manage their own health, care and wellbeing. Parents told us they felt confident in managing their children's needs. Parents and children were supported emotionally.

Dignity, respect and compassionate care

- The majority of parents we spoke with felt they were treated with dignity and respect by community staff. They said that staff were approachable and encouraged questions and listened.
- There was feedback collected from parents with children using the therapy services but no survey across the service to get feedback from clients using the children's community service.
- Most parents described staff as supportive and informative.
- We observed that most of the individual community staff treated parents, carers and children with respect. On one occasion we observed that a staff member kept their focus on a child's presenting condition rather than responding to the growing distress of the child.
- We saw examples of client information in all children's centres and clinical areas we visited, such as leaflets about the children's services and a variety of other local services to support children and young people's social and cultural needs. We observed staff recognising and respecting people's personal, cultural and social needs. We observed good care and support provided by staff who were sensitive and encouraging to children.

Children were included in discussions and decision making. For example, in the enuresis clinic children were asking questions, with the nurse ensuring the children fully understood the agreed treatment.

- Staff understood and respected confidentiality. They explained to those young people and families they worked with the boundaries in confidentiality in regards to protecting children from harm.

Patient understanding and involvement

- We observed that staff took the time to tell children in an age appropriate manner what was going to happen and encouraged them to ask any questions about the treatment.
- We observed interaction between health visitors and parents being parent led. This meant that the needs of the parents were foremost and listened and responded to. Future care and support was always jointly agreed. Parents and carers told us that staff always involved them in decisions about care and treatment for their children. For example, one parent told us that a member of staff "is always there, a lifeline…..she helps me feel in control of all the changes every day".

Emotional support

- We observed that patients, and those close to them, were supported emotionally. Mothers we spoke with described discussions about their emotional wellbeing and how this had been supported. We observed staff supporting children emotionally in clinics by nursing and therapy staff.
- When women were seen antenatally and postnatally they were asked about their emotional wellbeing. Staff told us that postnatal groups ran at local children's centres facilitated by the nursery nurses. However, staff told us these were being stopped to focus on achieving key performance indicators. The postnatal groups offered social interaction and parenting information and support for parents with young babies.
- The 'Strengths and difficulties' questionnaire was used with looked-after children as a behavioural screening tool to assist in the prediction of emotional health problems.

Good

Are services caring?

Promotion of self-care

- Parents and children were supported to manage their own health, care and wellbeing. Both individually and in groups for example through anticipatory guidance on minor ailments, healthy eating, breastfeeding, introduction of solid food, baby massage, reducing the risk of sudden infant death, child safety, child development and behaviour management. Also by signposting to relevant services for support. Parents told us they felt confident in managing their children's needs.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated responsive as 'requires improvement'.

Community children and young people's services were commissioned with indicators to monitor operational service delivery. The services were not informed by the needs of the population and not addressing the needs of different people.

The initial assessment within 28 days for looked after children target were not met. The waiting list for the learning disability service was not meeting the 18 week waiting time target.

Staff had had training in equality and diversity and individually took account of patient needs but services were not offered to support the needs and preferences of different people that might be based on age, gender, race or religion. Interpreter services were available but information leaflets were only printed in English.

There was not a consistent way of logging, investigating, responding to and learning from complaints. Most staff did not know the process for handling complaints. People we spoke with did not know how to make a complaint or raise concerns. Where concerns had been raised, these were not always addressed.

Staff told us that they prioritised work with people in vulnerable circumstances and would see people at times and places convenient for the young people and parents or carers. We saw evidence of person-centred care that showed community staff were responsive to individual needs and worked flexibly with people towards improved health and wellbeing.

Children had good access to services, and parents could attend appointments with health visitors and at child health clinics at convenient time.

Planning and delivering services which meet people's needs

- There was no population information or needs assessment informing service provision.
- The service managers of the community children and young people's service told us they had a good working relationship with the commissioners. The school nursing and occupational therapy services provided were commissioned by Buckinghamshire County Council Public Health. The health visiting service and FNP service were being shadow commissioned by Buckinghamshire County Public Health with full transfer planned in October 2015. Health visiting services nationally were being commissioned by local authorities from October 2015.
- There were separate service specifications for each service and regular monitoring meetings to review key performance indicators.
- The community paediatricians were provided by a block contract. The looked-after children/youth offending service, physiotherapy, nurses working with children with a learning disability, and the enuresis nursing service were commissioned by the Clinical Commissioning Group (CCG). Some separate service specifications with special schools regarding nursing and occupational therapy, and colleges regarding occupational therapy and physiotherapy provision, were commissioned.
- The trust had achieved its trajectory for the training and recruitment of health visitors and the following month the new health visitor universal family offer with an expanded service specification would start. The service specifications for health visiting and school nursing were aligned with the Healthy Child Programme (HCP).
- The service specification in school nursing due to start the following month had been significantly expanded to include routine screening and response to identified needs using a new database tool. This would be included in performance measures. The immunisation programme delivered by the school nursing service was commissioned separately by NHS England.
- The FNP had a client on their advisory board. In other community children and young people's services there was no evidence that children and young people were engaged in the planning and design of services.

Equality and diversity

- Staff individually took account of the needs of different people and offered appointments convenient for clients. There was a monthly child health clinic held at a

Requires improvement

Are services responsive to people's needs?

Women's Refuge. However, we did not see other services taking into account the needs and preferences of different people , for example on gender, race, religion or belief and sexual orientation
- We observed that the clinical areas we visited were accessible to people with disabilities.
- There was an interpretation service where an interpreter could be booked to join staff members for appointments. The leaflets for clients we saw were in English, and we did not see leaflets in other languages.
- Staff received equality and diversity training as part of their mandatory training.

Meeting the needs of people in vulnerable circumstances

- Health visitors and school nurses undertook review health assessments for looked-after children, identified health needs and took action on these. Staff told us that they prioritised work with people in vulnerable circumstances and would see people at times and places convenient for the young people and parents or carers.
- Children centres positioned in areas of multiple deprivation often accommodated regular child health clinics and these were well used. Health visitors provided a regular child health clinic at a women's refuge.
- There were coordinated pathways for children with complex needs and we saw examples of joint working to meet these needs in the combined community physiotherapy, occupational therapy and speech therapy clinics.
- Community physiotherapists and occupational therapists reported difficulties in getting toys they used in their role. This meant it was difficult to create an age-appropriate environment for children to be treated in.
- We observed that staff provided information on how to access services and support and in various formats.

Access to the right care at the right time

- The trust had improved its performance but was failing to meet the Initial Health Assessments target for looked after children within 28 days. There was an Ofsted workstream working to address this.
- The community children and young people's service offered its service between the hours of 9am and 5pm Monday to Friday throughout the year. Parents rang the service directly for advice and could arrange an appointment. The health visiting New Birth Visit and 'transfer into the caseload' appointment had a time frame to be achieved by, for example within 2 weeks of birth and at 6 weeks. Other appointments were either sent out or arranged directly with the parent. Community staff were responsive to individual needs and worked flexibly with people towards improved health and wellbeing. In the home visits we observed, health visitors offered support at times and places convenient for the clients.
- Child health clinics were held regularly in children's centres, health centres, hospitals, community centres and surgeries, and parents were able to access these as they wished. Parents could also ring health visitors for advice or leave a message for the health visitor. Staff told us that sometimes they were not able to respond to needs of clients in a timely manner, having to prioritise the needs of clients and the demands of the caseload.
- The community children and young people's occupational therapy service offered 74% of people an appointment within 6 weeks, with 99% within 18 weeks. The physiotherapy service on average offered 71% of people an appointment within 10 weeks, with 95% within 18 weeks. The community paediatricians offered 78% of people an appointment within 11 weeks, with 99% within 18 weeks.
- We did not see data on the enuresis service or the learning disability nurse service. Staff in the learning disability nurse service told us when they received a referral it was put onto the electronic system, then at the monthly team meeting a health needs assessment was done. This happened within 18 weeks. However, a nurse was not allocated for a further 3 to 6 months after that assessment. Staff were not sure of the definitions around targets. People could therefore wait beyond the 18 week target set for an appointment to be assessed fully by the service. Staff we spoke with told us that access to the continence phone line was problematic and the process was unclear.

Complaints handling (for this service) and learning from feedback

- People we spoke to who use the service did not know how to make a complaint or raise concerns. We did not observe any leaflets or information on display in the areas we visited.

Requires improvement

Are services responsive to people's needs?

- Two parents told us that the response they received from the Patient Advisory and Liaison Service (PALS) was weak and did not address their complaint. From the information provided we were unable to see what action had been taken to address complaints.
- Most staff did not know the process for dealing with complaints.
- Staff told us that on occasions complaints were dealt with informally and would not be logged.
- There was not a consistent way of logging, investigating, responding to and learning from complaints. For example, there were complaints recorded about the supply of nappies from the continence service, but there was no information from the trust on how these complaints had been dealt with.

Inadequate

Are services well-led?

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

Summary

We rated well-led as 'inadequate'.

The trust did not have a strategy for children and young people's services. Staff did not know and understand what the vision, values and strategy were for the trust. The majority of staff told us that the services they delivered were not high on the trust agenda.

Staff within school nursing team told us that they were discouraged or not heard when they raised concerns about being able to deliver services safely. The concerns included being told to take on responsibilities beyond their competencies and workload pressures leading to staff being unable to perform some of their role. A new database tool had identified risks in children but staff were unable to address these. There had been a lack of management support and staff were dissuaded and bullied if they raised concerns. Staff reported their concerns to managers but these had not been acted on and these had not been escalated to the board. The culture was one where staff felt disempowered to act.

The was a process of governance and performance was monitored but many staff told us the culture was focused was on achieving performance indicators and their skills and many aspects of the preventative work were not valued. The health visiting and school nursing policies we reviewed had not gone through a governance process and had not been ratified. Risks were not appropriately identified, monitored and assessed. This was being impeded by individuals rather than processes. There were not robust lone working arrangements or an escalation process. The trust board had only recently started to engage with the service to understand what services were delivered and identify areas of concern.

The service supported innovative practice but staff were not well resourced or given time to contribute or deliver this effectively. The service did not have plans for future improvement or sustainability, in terms of staffing, succession planning and managing finances.

Patient feedback was developed in therapy services and in the Family Nurse Partnership team but there were limited opportunities for people who used the service to give feedback elsewhere.

The Family Nurse Partnership (FNP) service had the right structures as defined by the national programme, and was assessed in its annual report as performing well.

Service vision and strategy

- The trust did not have a local vision or strategy for the community children and young people's service.
- Many staff told us they did not know and understand what the vision, values and strategy were for the trust. The majority of staff told us that children and young people were not high on the agenda. Most staff we spoke with told us that they felt the focus of the trust was on acute services.
- There were separate service specifications for each service included operational and service developments. Many of the health visitors and staff in the school nursing teams we spoke with knew most of what was included in the new service specification and what they would be measured on.
- Senior staff told us that the strategy for recruiting health visitors in line with the national 'Call to action: health visitor implementation plan 2011–2015' had been achieved.
- The trust's vision was to provide 'safe and compassionate care every time'. Staff told us they were not informed of the trust's vision and when they received information it was from their team leaders.
- One member of staff told us a communication quarterly was sent by the chief executive but the majority of other staff were unaware of this. Staff did not know the trust strategy or their role within it

Governance, risk management and quality measurement

- Staff across the service had regular operational meetings within their teams and at their locality. These meetings looked at caseload numbers and needs, and risks related to this.

Inadequate

Are services well-led?

- Performance indicators that were monitored on a monthly operational dashboard for children and young people including waiting times, national school measurement programme achievement, immunisation rates, development reviews and screening .
- The trust had the right structures and processes in place for the Family Nurse Partnership service and the annual review of the service reported a very high performing team.
- The health visiting and school nursing policies we reviewed had not gone through a governance process and had not been ratified.
- The corporate risk register identified risks of staffing vacancies, compliance with statutory training and appraisals, the failure to meet Initial Health Assessments target, the vacant designated doctor post for safeguarding and one location that did not meet medical records guidance. There were actions identified in response to these risks.
- In trust public board minutes from three meetings within the previous five months, there was limited reference to the community children and young people's service. There had been a recent presentation by the service to the board that gave an overview of children's community services and that more were planned. Staffing levels in the children's community services were an agenda item for a future board meeting. There was also reference to a serious incident, but there was very little information on how this was being tracked.
- Staff told us they used shared diaries, worked together and mobile phones for their safety while lone working. There was a lack of phone signal in some areas, and staff did not carry safety devices with two-way audio GPS technology. The lone working policy advised that lone workers attended mandatory conflict resolution training and undertook risk assessments. Staff told us that there was not a system to identify known risks with an individual or location. There was no information available from the trust on the percentage of staff who had attended conflict resolution training. The systems used were not robust in ensuring the safety of staff.

Leadership of this service

- The chief nurse was the named lead for children, transition and safeguarding. Many staff told us they did not know the names of those on the board and their responsibilities. They had not seen any of the leadership on quality safety walkabouts.
- The community children and young people's service had three operational leads (one of whom was also the head of the children and young people's service) who each had between five and six teams. The teams were made of one discipline who worked in a locality. This structure had been in place since September 2014 and each team had a team leader. Health visitors told us that a number of health visiting teams had a significant number of new inexperienced health visitors following this reorganisation. Staff within the teams we spoke with told us that the service was 'management light'.
- During the inspection we met with a variety of staff across the community children and young people's service. When we asked to speak to people in senior roles and middle management roles we found several were unavailable to speak with us, as they were either on sick leave, on annual leave, or had pre-existing work commitments.
- There were mixed views about the support staff received from managers. Staff within community physiotherapy and occupational therapy were positive about the support they received from their team leaders.
- Many staff told us that they offered and did give help to colleagues in other caseloads if those teams were struggling to manage their work and they were able to help. Staff we spoke with were unsure about escalation processes and contingency planning.
- Some managers told us they felt pressurised and that as well as managing staff they were leading on big trust-wide projects. These projects required dedicated time and resources which was not allocated.

Culture within this service

- The chief executive described the trust as a learning organisation and spoke of staff going the extra mile and working hard to fill the gaps. All community staff we spoke with described the colleagues in their teams as supportive and felt they communicated and worked well together.
- Many staff from health visiting and school nursing told us that the focus was on achieving performance

indicators and that many aspects of their preventative work and skills were not valued many staff told us that they did not take adequate breaks due to workload pressures and some worked additional unpaid hours.

- Health visiting teams from certain urban and rural areas and school nursing teams told us they had reported their concerns about heavy caseloads and not being able to fulfil some of their roles to team leaders. Staff told us that some managers dissuaded staff from reporting concerns and were not supportive. Band 5 nurses within school nursing teams told us about concerns they had with safety within their role. They had been asked to take on work outside their roles; when they asked for training to enable them to do this work it had not been provided, and they did not feel competent or adequately supervised.
- Some staff told us that if they spoke up they were "told off" and "bullied" by some managers and felt pressured from above. Band 5 staff gave us examples of when they had been pressured in a way they believed was unsafe; one was in undertaking assessments and contributing to child protection case conferences and plans, another was being unable to use the new database tool to address identified unmet need. Staff told us they reported their concerns to managers but felt disempowered at work and were unable to take concerns further. Concerns had not been raised under the trust bullying and harassment policies.
- Laptops and the electronic system to access the new database tool were ordered but not currently accessible to staff. The new service specification had set out expectations for the use of this tool extensively in addition to pre-existing ongoing work. Staff had reported their concerns to managers but were told they "were not being corporate by raising concerns, as this is what they had to do as it had been commissioned."
- By discouraging staff from raising concerns, the trust could not be assured that risks were being adequately identified and managed**.** Concerns were not appropriately escalated to the board and not identified in trust minutes or trust documents.

Public engagement

- The occupational therapy service used evaluation forms, for example with families when working on a child's balance and motor skills, and in gaining feedback about their school advice clinic.
- Senior staff told us that methods to gain feedback from the health visiting and school nursing service were being developed.
- The FNP had a client on their advisory board, it also had a client share their story at the Family Nurse Partnership (FNP) annual review and included quotes from clients in the review.
- There was external partner organisation feedback in 2014 from looked-after children and traveller communities about their views on accessing healthcare and support and what would improve access. Of the 38 looked-after young people, 31% of them knew about their health plan, 74% felt their views in regard to healthcare were listened to, and many relied on their carers for advice and information on healthcare. Feedback from travellers praised home visits by health visitors. It stated that specific information on child health clinics would have improved access, and this was being provided.

Staff engagement

- Most of health visiting and school nursing staff we spoke with told us that the new service specification had been imposed on them with little consultation. Staff spoke of being told to stop certain key proactive, preventative work.
- The staff survey showed that the trust did not perform well in the work pressure felt by staff, and in staff working extra hours. It showed that the trust did not perform well in staff feeling secure in raising concerns about unsafe clinical practice. Some staff told us they felt 'done to', with a lack of consultation about service developments.
- The locality teams met monthly and the teams within the locality met weekly. The two operational leads and some health visitor team leads met with the head of children and young people's service (also an operational lead) bi-monthly; this was to discuss caseloads and performance. The head of children and young people (also an operational lead) then met regularly and reported to the assistant chief operating officer. The assistant chief operating officer was within the 'Specialist services division – women and children's directorate, children and young people's service'. During our inspection they were appointed permanently from having been in an interim role.
- Staff told us that information was cascaded down from the head of children and young people's service. They

reported that information going up was stopped at either the team leader or operational lead level as this depended on the people in these posts. The head of children and young people told us that they cascaded information to the team leaders who then disseminated information at the locality meetings.

Innovation, improvement and sustainability

- Staffing levels were a concern in health visiting and school nursing teams. Managers told us there were difficulties in recruiting staff with one factor being the presence of London weighting allowance in a neighbouring trust. The trust did not have a plan to address this.
- Staff gave mixed views on succession planning. A range of staff across community children and young people's services told us that staff were put into management roles without enough support and development and that some were ill equipped in these roles.
- The school nurses were the first in the country to use a new online resource tool. Through this online portal families were sent questionnaires to identify health needs in their children, their identified health needs were then sent to the school nurses allocated to their children's schools.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Staffing** **How the regulation was not being met:** The trust did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients. • Staffing vacancies and guidance not being met - health visitors, school nurses, Family Nurse Practitioners. Looked after children. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Supporting staff** **How the regulation was not being met:** The trust did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to patients safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal. • Safeguarding and mandatory training • Mental Capacity Act and Deprivation of Liberty Safeguards training.

This section is primarily information for the provider

Requirement notices

Regulation 23(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Assessing and monitoring the quality of service provision.** **How the regulation was not being met:** The trust did not have an effective operation of systems to enable it to identify, assess, and manage risks relating to incidents and near misses relating to the health and welfare of patients and others. • Staff unable to raise concerns • Incident reporting • Local audit programme • Management of LD waiting list • Patient feedback for services. • Service strategy • Leadership and culture concerns • Governance arrangements • Staff engagement • Budgetary constraints Regulation 10(1)(b) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Care and Welfare** **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The trust did not take proper steps to ensure that each patient was protected against the risks of inappropriate and unsafe care.

- Risk assessment documented appropriately
- Staff appropriately identify and can respond to patients risks
- Universal antenatal contact with health visitor
- Multi-disciplinary team working to coordinate care

Regulation 9 (1)(a) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

Complaints

How the regulation was not being met:

The trust had not protected people against the risk of unsafe or inappropriate care or treatment through an effective complaints system

- Patients not aware of how to make a complaint or concern
- Complaints not logged, investigated, responded to appropriately

Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.