Tower Hamlets GP Care Group CIC

Family Nurse Partnership & Health Visiting

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We had not previously inspected this location. We rated it as good because:

- Leaders had a clear vision for the service and were making changes to ensure the sustainability of it given national staff shortages. The service was in the process of implementing a new staffing model to meet the local population needs. They had started to introduce a skill mix so non-health visitor staff could help improve their delivery of the Healthy Child Programme (HCP) mandated milestone checks. They adopted a 'grow our own' approach by training and employing student health visitors who passed their courses.
- Staff were supported to do their jobs well. Staff mostly kept up to date with their mandatory training, and there were opportunities for them to complete additional training and develop in their roles. Staff were competent for their roles and received training, supervision and appraisals. New staff introduced through the skill mix review were required to complete competency frameworks.
- Staff received regular safeguarding supervision. Staff understood how to protect adults and children from abuse and the services attended multidisciplinary meetings with other agencies to do so.
- The service controlled infection risk well. The environments and equipment used by staff and children were kept clean.
- Staff provided parents with relevant and helpful written and verbal information. They monitored children's development and provided advice on things such as feeding, safe sleeping and safety in the home.
- The services mostly worked well with other healthcare professionals and partner agencies. They attended multidisciplinary meetings, provided training and guidance, and shared relevant information where appropriate, although staff sometimes did not respond to all information from other professionals, for example GPs, in a timely manner.
- Parents we spoke to were very positive about the service. They said staff were kind, knowledgeable, and discussed their wellbeing as well as their child's development.
- The service had access to interpreters and British Sign Language services where required. Patient records contained alerts if these were required.
- The new senior leadership team were aware of most of the risks to the services and had plans in place to mitigate them. Managers had good oversight of data relevant to the services. They used this data to make decisions and improvements.
- Managers encouraged staff engagement and an open organisational culture. Senior leaders were accessible to staff at all levels. There was well-being support in place which was valued by staff.
- Senior leaders had oversight of incidents and complaints. Managers investigated incidents and complaints and shared the lessons with staff to minimise the risk of them happening again.

However:

- The health visiting teams did not have robust systems in place to ensure oversight of all children and families. Each team held a list of the vulnerable children, but health visitors did not always update this list fully. Managers were aware this was an issue and planned to introduce a new system to ensure better oversight.
- Staff did not always update their electronic diaries with their appointments, which meant managers did not always have oversight of their commitments if staff went off sick or on leave, and caseloads were not always reallocated promptly when staff were on long-term leave or had left the service. The service planned to implement caseload weighting and caseload management processes.
- The service did not complete all checks required by the Healthy Child Programme (HCP). Performance was improving and managers had plans to ensure more checks were completed.

Summary of findings

- The service did not have a robust process in place to protect staff working alone. The service relied on staff updating their electronic diaries with their whereabouts, but this did not always happen.
- The provider's Safeguarding Children policy did not accurately reflect current national guidance. Safeguarding supervision action plans did not usually contain timescales for completion. Furthermore, we did not see evidence these actions were reviewed so it was unclear how the service assured itself they had been completed.
- An audit of patient care records had not been completed since 2020. We saw a range of quality in the care records we looked at.
- Staff did not have access to health information in local community languages, such as leaflets on common health issues.
- Staff did not always record that they had apologised or given children and families information or support when things went wrong.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for children, young people and families	Good 	See summary above.

Summary of findings

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Summary of this inspection

Background to Family Nurse Partnership & Health Visiting

The Family Nurse Partnership (FNP) and Health Visiting services are part of an integrated 0 – 19 service which also includes the School Health service. The Healthy Weight Healthy Nutrition and Baby Friendly Initiative team provides a pathway based within the 0 - 19 services. The 0 -19 services are commissioned by the London Borough of Tower Hamlets Public Health Division and are provided by the Tower Hamlets GP Care Group. This is a Community Interest Company (CIC) owned by a federation of GP practices in Tower Hamlets.

The School Health service, which provides care to children between the ages of five and 19, is registered with CQC under a separate location. We inspected School Health separately the week prior to this inspection.

The Health Visiting team's delivery model is based on the nationally mandated Healthy Child Programme (HCP). The HCP requires them to complete five mandatory checks; antenatal 28-week contacts, new birth visits within 14 days, six to eight-week reviews, one-year development reviews, and two to two-and-a-half-year development reviews.

The FNP part of the service is a voluntary programme for first-time mothers that aims to support young mothers aged 21 and under from the early stages of pregnancy until the child is between one and two years old. Mothers are partnered with specially trained family nurses who regularly visit them at home or in community venues and use a psycho-educational approach, focusing on positive behaviour change. As well as focusing on health, the FNP aims to help mothers in other areas of their lives, such as housing, employment and finances, and independent living skills, as these impact on family health and well-being. The FNP also helps deliver the HCP as part of their intensive visiting programme.

The FNP and health visiting services have links to Children's Centres, GPs and other professionals from the health and social care sector.

The regulated activities attached to this service are diagnostic and screening procedures, maternity and midwifery services, and treatment of disease, disorder or injury. There is a registered manager in post.

There had been no previous inspections completed at this location. Therefore, no compliance actions / requirement notices or enforcement needed to be checked.

What people who use the service say

Parents we spoke with were very satisfied with the care they received from the Family Nurse Partnership (FNP) and health visiting services. We spoke with 10 parents. They said staff were kind, knowledgeable, and discussed their wellbeing as well as their child's development.

How we carried out this inspection

This was a routine inspection of a service that had not previously been inspected. Our inspection team was comprised of two CQC inspectors, one inspection manager, and two specialist professional advisors with backgrounds in safeguarding and health visiting. During this inspection we:

- Accompanied staff on home visits and observed their interactions

Summary of this inspection

- Visited children's centres where clinics were held, toured the environment, and observed child development appointments
- Reviewed electronic care records detailing the care and treatment of 13 children. Some of these children were on an enhanced care pathway due to additional needs and vulnerabilities and some were on a universal pathway offered to all families as part of the HCP
- Spoke with four senior leaders of the service including the executive director for strategy and governance and the chief operating officer
- Spoke with 25 staff members, individually or during focus groups, including family nurses, health visitors, student health visitors, community staff nurses, community support workers and community nursery nurses
- Spoke with 13 direct line managers of teams within the FNP and Health Visiting service, either individually or during focus groups
- Spoke with 10 parents about their experience of the services
- Reviewed five safeguarding supervision records and interviewed the Named Nurse for safeguarding
- Looked at a range of policies, procedures and documents related to the service
- Reviewed a sample of four incidents that had been investigated by the provider and two complaints.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure that it has robust systems in place to oversee and monitor the quality and safety of care provided to vulnerable children and families and which can be used to underpin improvement work.
- The provider must ensure there is robust guidance and practices around lone working to ensure the safety of their staff.
- The provider must ensure that the safeguarding children policy and any associated procedures are thoroughly reviewed to check they accurately reflect current national guidance and are relevant to the current provider.

Action the service SHOULD take to improve:

- The service should ensure that they continue work to improve performance in completing checks for the mandated milestones outlined in the Healthy Child Programme.
- The service should ensure consistent approaches to frequency of meetings and sharing risk information with other agencies, for example with local GP practices.
- The service should implement new tools and processes to enable effective reallocation of caseloads when staff members go on long-term leave or move job roles.
- The service should ensure they complete regular audits of patient care records to ensure they are of a high standard and contain all necessary information.
- The service should review the need for key information leaflets in local community languages and take steps to introduce them if necessary (online and/or paper versions).
- The service should ensure that staff always offer an apology to people when things go wrong and record this when they have done so.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Community health services for children, young people and families

Good

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

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

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and most staff completed it.

Staff mostly kept up-to-date with their mandatory training. The training was comprehensive and met the needs of children, families and staff. Staff from the health visiting team and the Family Nurse Partnership (FNP) team had mandatory training which included basic life support, domestic violence awareness, and safeguarding. Health visiting staff also had training on consent, health and safety awareness, and records management. Staff told us the courses were available online which made them accessible for everyone.

At the time of our inspection, overall compliance with mandatory training was 89% for the health visiting service and 98% for the FNP service. In July 2022, 77% of the health visiting team and 100% of the FNP team completed their basic life support training. This had improved on previous months as staff were now able to complete basic life support training in face-to-face sessions.

Managers monitored mandatory training and alerted staff when they needed to update their training. They were able to view training compliance across each team within the borough using an electronic dashboard.

Staff and managers told us training was encouraged by the provider. This included the mandatory training and additional courses such as unconscious bias and trauma informed training.

Senior leaders told us there were plans to train staff on autism and learning disabilities. This became a requirement in July 2022 as a result of the Health and Care Act 2022. At the time of our inspection staff were due to have training in autism and they were awaiting training on learning disabilities.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the provider's safeguarding policy did not fully reflect current guidance.

Community health services for children, young people and families

Good

Staff received training specific for their role on how to recognise and report abuse. At the time of our inspection, all the Family Nurse Partnership (FNP) staff and most of the health visiting staff had completed their safeguarding training. Almost all had received training on domestic violence. Of the 15 board members and senior managers, 12 were up to date with the mandatory safeguarding training relevant to their roles. Three board members had not completed the safeguarding training which was not in line with the provider's safeguarding policy.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Between January and March 2022, the health visiting service made 10 safeguarding referrals. Staff knew how to escalate concerns and could name other specialist services they could contact for support if working with victims of domestic abuse. Staff felt they had enough training and support to help them deal with safeguarding matters.

The service had a dedicated safeguarding team that staff could access for advice. Staff received safeguarding supervision, the frequency of which varied between staff who held caseloads and those who did not. For example, caseload-holding health visitors received safeguarding supervision every quarter, whereas non-caseload holding nursery nurses received annual group safeguarding supervision. Safeguarding supervisors were expected to have a minimum of four group supervision sessions a year. Family nurses in the FNP received termly safeguarding supervision but also received weekly supervision with the FNP supervisor. At the time of our inspection, safeguarding supervision compliance amongst the FNP team was 100% and compliance in the health visiting team was 94%. The safeguarding Named Nurse had oversight of supervision rates and followed up with those who were yet to complete it within the specified timeframe. The staff we spoke with said they found safeguarding supervision helpful.

The provider's dedicated safeguarding team attended multiagency risk assessment conferences (MARAC) and worked in partnership with the multiagency safeguarding hub (MASH) to ensure that children and young people were kept safe.

The provider's safeguarding team reviewed every incident recorded to check whether they contained any safeguarding elements. A dashboard detailing safeguarding key performance indicators was used to track progress.

We viewed five safeguarding supervision records and found they were clear in detail and easy to follow. Each was uploaded to the child's electronic record which made them accessible. However, most actions outlined on the supervision records did not contain timescales for completion and none of the five records appeared to have any reviews of the actions, so it was unclear if or how staff or supervisors assured themselves they were completed.

A summary of safeguarding supervision was sent to line managers in order to highlight any training needs. Notes taken from group supervision sessions were comprehensive and contained links to further learning and resources. At the time of the inspection, all safeguarding supervisors within the health visiting service were having their work peer reviewed with the aim of finding themes for future learning and improvements. The service had plans for additional safeguarding supervision audits and were developing tools to assist this.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We observed staff ask parents about matters such as female genital mutilation (FGM) and domestic abuse. Staff were expected to prioritise and attend all child protection meetings and upload meeting minutes to the child's record within 24 hours. Over a 12-month period, the FNP team attended 100% of their scheduled case conferences. These are multi-agency meetings led by the local authority. The health visiting teams mostly exceeded their internal 95% attendance target. The provider had recently introduced a spreadsheet of child protection meetings so management had oversight and could support allocation where needed.

The provider's safeguarding policy did not fully reflect current guidance. Managers knew that the safeguarding children policy had not been reviewed by the set review date of May 2021, and they had plans to review it. However, we noted that the policy did not reference some important changes in guidance that had occurred prior to its issue in 2018 and it reflected the previous contract holder's organisation. For example, it referenced terminology relevant to acute hospitals. The policy also did not outline clear governance arrangements and accountabilities for safeguarding. It referenced outdated guidance and legislation throughout, for example, the Working Together to Safeguarding Children 2015 statutory guidance. Significant changes were made to the 2015 guidance in July 2018, three months before the provider's policy was issued, but it did not reference the 2018 guidance. This meant the policy did not provide staff with up-to-date guidance.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Areas used by families were clean and had suitable furnishings which were clean and well-maintained. The children's centres were responsible for the for general cleanliness and the health visiting staff were responsible for cleaning their equipment. Staff cleaned equipment after patient contact.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff changing their aprons and gloves between appointments. Hand sanitiser was readily available and used. Staff had access to and wore face masks to reduce the risk of Covid-19. We saw a family nurse disinfect plastic toys before going to an appointment, and health visiting staff cleaned toys children had played with at the children's centres. Most FNP and health visiting staff had completed the mandatory infection control training course.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

Family nurses were based in an office so they could access paperwork and tools licensed by the Family Nurse Partnership National Unit. They told us all their contacts with parents and children were face-to-face, either in community settings or within the family's home.

Staff within the health visiting service had appointments with families in their homes or at children's centres. Due to the pandemic and the provider consolidating their estates, staff often worked from home to complete notes. At the time of our inspection, the provider was moving their main office base and had plans to explore other bases where staff could work.

The service had enough suitable equipment to help them to safely care for children. Staff mostly used weighing scales that belonged to the health visiting team, but also had access to scales belonging to midwifery teams. Most scales had stickers to show they had been calibrated.

Rooms at the children's centres were used by other professionals. The centres were responsible for general cleanliness and the health visiting staff were responsible for cleaning their equipment. Staff were observed cleaning equipment after use. They also disposed of clinical waste, changed their personal protective equipment, and sanitised their hands between each appointment.

The provider did not have a robust system in place to support staff who were lone working. Staff did not always follow the provider's lone working guidance. The lone worker policy had not been reviewed since 2016. Leaders were aware and had plans to update it.

As an interim measure, the provider implemented guidance in 2020, which stated staff must document all appointments and work-related activities in their electronic diaries. Health visiting staff were required to check in at the beginning of the working day and check out at the end of the working day with the duty health visitor. Family nurses were required to check in and out electronically at the start and end of the day. However, staff did not always complete their electronic diaries in full, which meant that managers may not know about each member of staff's appointments if cover was needed or they did not call in at the end of the day. Senior leaders acknowledged that staff were not always following the procedures in place.

Staff told us having a lone working device from which they could raise an alarm would make them feel safer.

Assessing and responding to patient risk

Staff completed and updated risk assessments for most parents and children, but in some cases they did not complete these or share key information with other professionals. The service did not have an effective oversight system to monitor their most vulnerable children and families and did not always have oversight of their staff member's appointments.

We reviewed 13 electronic care records during our inspection. Staff routinely assessed risks for most children and their families and ensured that most records were up to date. Alerts were present on the electronic patient record system where necessary, for example, if a child was on a protection plan.

Staff did not, however, always follow up on information shared from other professionals. Three out of 13 records we looked at showed staff did not record that they adequately assessed and responded to patient risk or shared information with other professionals. For example, one child had been on an enhanced pathway of care due to domestic abuse within the family and maternal mental health issues. The child was moved to a universal pathway in January 2022 because the health visitor said there had not been any further concerns about the family since January 2021. However, the record showed health visiting staff and the GP had not had contact with the child since May 2021. Following a meeting with the GP, a plan was made to conduct a new needs assessment and review current risks, but there was nothing in the records to suggest this happened. The provider investigated and found the case had not been reallocated after the health visitor left for another job role. Given the recorded domestic abuse and maternal mental health concerns, the lack of clarity within the records, and the omission with reallocating the case, the child's welfare could have been put at risk. The service planned to implement caseload weighting and case management processes. These would involve three-monthly reviews of cases and help escalate cases in need of reallocation, and also determine the required level of contact to meet individual needs.

The service did not have an effective oversight system to monitor their most vulnerable children and families. Teams within the health visiting service each kept a document listing the most vulnerable children which could be accessed by staff and managers. Staff were expected to keep the information up to date, including vulnerabilities, recent visits and

future review dates. However, the health visitors did not always complete this information. For example, we viewed a sample from the document and found one health visitor had noted several reviews with families required in 2021, but it was unclear if these had taken place or not. We were told this health visitor had been on long term sick leave. It was not clear from the document if these vulnerable families had been reallocated to another member of staff in the health visitor's absence. We also reviewed a sample of incidents investigated by the service, and three related to children not having follow up contact with health visitors despite known safeguarding concerns. The causes included lack of updates to the vulnerable list document and failure to reallocate cases when staff went on long-term sick leave. Furthermore, there was no back up option if the document was lost or corrupted. Senior leaders planned to introduce a caseload weighting and oversight tool in autumn 2022 so this information could be captured within their electronic patient record system rather than on a separate spreadsheet.

Managers did not always have oversight of missed appointments. Staff were expected to update their electronic diaries to reflect their whereabouts and planned appointments, but this did not consistently happen. This meant that when a health visitor had unplanned absence from work it was difficult for managers to work out whether any appointments needed to be covered. The electronic patient record system also did not flag up incomplete records or show appointments that had no outcome. This could result in missed opportunities to follow up with children and families and in information being lost or inaccessible. Senior managers admitted that children missing appointments was one of their biggest risks. They were trying to mitigate some of the risks, for example, by planning to implement reviews of all cases at least every three months.

Staff followed agreed processes to transfer children to other services. When vulnerable children moved out of Tower Hamlets, we saw evidence of staff completing the vulnerable child transfer checklist. This was in line with the provider's policy.

Health visiting staff continued to offer virtual appointments, which were introduced over Covid-19, if the family had previously been seen face-to-face and did not have any additional needs. However, managers wanted most appointments to return face-to-face, and there was an expectation that families on enhanced care pathways would be seen in person. We saw evidence of face-to-face appointments taking place for vulnerable children as well as children with no additional needs.

The service was in the process of implementing a single point of access, in which all referrals to the service would be received in one place. Managers said this would give children, families and professionals better access and quicker responses, as well as providing more oversight of missed appointments. They were planning to introduce a centralised administration team to further improve support functions.

Staffing

The service was in the process of implementing a new staffing model to ensure there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. At the time of the inspection, the service was not meeting all aspects of the Healthy Child Programme (HCP) and staff told us they felt stressed. Managers reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service was not able to consistently deliver the five mandatory checks of the HCP, but managers were working on a staffing model to improve this in the future. The HCP, published by the Department of Health and Social Care in 2009, gives public health services a framework for delivering the contacts every child aged 0 to 19 should receive.

Community health services for children, young people and families

Good

Most of the staff we spoke with said staffing was problematic and that they had to work additional hours. They told us their workload was very high which was causing stress and anxiety among many. They said one of the main challenges was the high number of vulnerable families in the area which impacted staffing capacity, rather than caseload numbers. Staff felt that although the service appeared to be fully staffed, the staffing levels did not take into account the additional work associated with working with families with high support needs. All managers supported staff by conducting visits and holding caseloads when staff were overloaded. The service planned to introduce a caseload weighting model, which aimed to identify whether staffing levels matched the local population needs.

The service had high turnover rates for health visitors. Between three and six health visitors left the service every three months between April 2021 and March 2022. The sickness rate for health visitors varied between 5% and 11% within this timeframe.

The FNP service, which worked with vulnerable young parents, had a waiting list. Two new family nurses were due to join the team shortly after our inspection which should reduce the waiting list. Managers were unable to build capacity in the FNP through changes to the skill mix due to the specialities required.

Senior leaders recognised the impact of national recruitment issues on the service and had begun making changes to mitigate many of the risks associated with staff shortages. The service was undergoing a transformation with the aim of improving service delivery. For example, the service had introduced a new model of staffing following a skill mix review and there were plans to review guidance documents in order to streamline processes. The skill mix review had identified areas where other professionals could appropriately support health visitors, for example, with some developmental checks and tasks in clinics. Managers were introducing training and competency assessments for new staff so they could complete tasks safely.

Most aspects of the skill mix review had been completed, but managers still planned to introduce nurse specialist roles, such as perinatal mental health nurses. The provider had also adopted a 'grow our own' approach by training and employing student health visitors on completion of their external training. They had taken on four student health visitors each year and planned to increase this to six.

The service used bank and agency workers to maintain staffing levels. Managers made sure all bank and agency staff had a full induction and understood the service, and these staff received additional oversight and scrutiny whilst they settled in. All agency staff were on minimum three-month contracts so they could become familiar with the service. Most staff spoke positively about the use of bank and agency staff and the outcome of the skill mix review.

Quality of records

Staff mostly kept up to date records of patients' care and treatment. Records were stored securely and were easily available to all staff providing care, but they varied in the level of detail recorded.

During our inspection we looked at 13 electronic care records.

Patient notes were often comprehensive, and all staff could usually access them easily. We found a range of quality in the care record notes. Many were comprehensive, detailed and contained evidence of partnership working, but some contained fewer details than expected. We saw most assessments were clearly recorded and some included the staff member's professional judgements of the child's wellbeing.

Community health services for children, young people and families

Good

Senior leaders told us the last audit of care records was in 2020. Staff had received record keeping training in 2021, but records still contained some gaps. Leaders recognised the need for the training to be repeated and planned to conduct audits at least twice a year to improve the quality of records.

Some staff updated the records during appointments with families, but this was not always the case. We saw evidence some notes were written retrospectively, sometimes days later, and the reason cited as workload issues. We also saw some notes had been written in the evening, although it was not specified if this was due to workload issues or flexible working arrangements. During our inspection, we saw one member of staff handwriting brief notes on paper. This staff member told us the internet connection at the children's centre was poor, so they noted key information which they added to the system later.

Records were stored securely. Staff had access to them through the electronic patient records system.

Medicines

The service did not prescribe, administer or store medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored. However, when things went wrong staff did not always apologise or give children or families information and suitable support.

Staff knew what incidents to report and most knew how to report them on the provider's incident reporting system. Staff raised concerns and reported incidents and near misses in line with provider's policy. Managers investigated incidents thoroughly. They discussed expectations around reporting incidents with staff. Not all staff had received training on the system so leaders had made a business case for formal incident reporting training. This was approved and due to happen shortly after our inspection.

Staff understood the duty of candour. However, the service was not always open and transparent, and did not always give children and their families a full explanation if and when things went wrong. We looked at a random sample of four incidents investigated by the provider. Of these, three related to children lost to follow up and there were no recorded apologies given to the families.

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

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of children and families in their care.

Community health services for children, young people and families

Good

The health visiting service and family nurses aimed to deliver the Department of Health and Social Care's national Healthy Child Programme (HCP), although the health visiting service were not meeting most of their targets. The service had introduced 3 – 4-month checks, which are not mandated by the HCP, but chose to pause these with the agreement of their commissioners.

A family health needs assessment was completed during new birth visits and entered via a template onto the patient's care records. Needs assessments are based on an assessment triangle which looks at children's developmental needs, parenting capacity, and family and environmental factors.

The Family Nurse Partnership (FNP) service resumed face-to-face appointments shortly after the start of the pandemic. They delivered the HCP alongside a more intensive visiting programme than the health visiting service. Family nurses used materials and tools licensed by the National FNP Unit. The New Mum Star tool supported family nurses to discuss a range of topics related to first-time mum's lives, for example health or environment, and used these to set personalised goals. The frequency of visits from family nurses could be increased or decreased according to individual needs.

FNP and health visitor staff used the Ages and Stages Questionnaire Third Edition (ASQ-3) to measure developmental progress in children. During the inspection we observed staff using this tool to ask parents about their child's progress in areas such as communication, gross and fine motor skills, problem solving skills and their personal and social development.

Nutrition and hydration

Staff regularly checked if children and mothers were eating and drinking enough to stay healthy. They worked with other agencies to support children and families who needed additional support with this.

Staff made sure families had the information they needed to meet their nutrition and hydration needs. We saw staff discuss breast feeding, diet, weaning and feeding with parents. Information leaflets were available in children's centres and provided to families by staff. Most staff asked parents of babies if their child was being breastfed.

Patient care records included references to checking on children and mother's food and fluid intake and recommending changes if needed. There was also evidence of multi-disciplinary working. For example, we saw a patient care record where the family nurse had concerns about the mother's low food intake and body weight. The family nurse had contacted the mother's midwife who made a referral to a specialist healthcare professional.

Specialist support from staff, such as speech and language therapists, was available for children and young people who needed it. However, we were told the waiting list for these services was up to 18 months.

Patient outcomes

Staff monitored the effectiveness of care and treatment and were trying to make improvements from the findings to achieve better outcomes for children and young people.

Leaders used dashboards to monitor the service's performance and maintain oversight on the delivery of the mandated HCP.

Community health services for children, young people and families

Good

The health visiting team were not meeting their 90% targets for the five mandated checks of the HCP, but performance was improving. Leaders had agreed trajectories with the commissioners and had prioritised new birth visits and appointments for children on enhanced care pathways.

For quarter 1 2022-23 (April-June 2022), the average performance completed was:

- 17.7% ante-natal visits
- 88.1% new birth visits
- 85.2% 6-8 weeks visits
- 69.7% 1-year visits (completed by 15 months)
- 73.2% 2 - 2.5 years visits

Managers supported their staff by conducting visits and holding caseloads of vulnerable families themselves. However, figures still mostly fell below the provider's targets. By not having contact with families and children at the mandated milestones, staff could miss risks and developmental delays.

Leaders had recognised the issues and agreed an improvement plan with commissioners which was due to be reviewed. They were in the process of setting out trajectories to improve outcomes and planned to move to monthly data collection to have better oversight of changes over time. Managers said they wanted most appointments to return to being face-to-face following virtual appointments during the pandemic. They aimed for 80% of their appointments to be face-to-face by September 2022.

FNP performance data showed very few mothers left the service early, either while pregnant or once their baby had been born. There were between 72 and 74 parents enrolled on the programme each quarter, and between four to seven parents graduated from the service each quarter. The FNP team said parents could graduate after one year if they were doing well and no longer required the intensity the programme offered, although it was sometimes a challenge to move them on due to capacity issues in the health visiting team. In these circumstances, family nurses would sometimes hold caseloads for longer than necessary.

Competent staff

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

Staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of children and their families. The service had introduced a skill mix which resulted in the employment of newly qualified nurses and clinical support workers to help health visitors with some elements of the HCP. The provider had introduced competency frameworks for these roles to assure themselves staff completed tasks safely. These staff were also supervised during appointments before they were able to see families independently. However, the competency frameworks were manually completed and there was no centralised oversight system. This meant managers outside of the new staff member's immediate line manager did not have immediate oversight of competencies. We were told the provider was in the process of getting a new electronic system which would address this issue.

Managers gave all new staff, including agency and bank staff, a full induction tailored to their role before they started work. Inductions included office-based tasks and shadowing opportunities.

Community health services for children, young people and families

Good

Managers supported staff to develop through yearly, constructive appraisals of their work. For example, in the south west locality, 76% of eligible staff had completed an appraisal in 2021/22. Newer members of staff and a student health visitor received more regular one-to-one meetings with their managers.

Staff received regular management supervision. For example, for the north east locality, 79% of eligible staff received management supervision in June 2022. Staff also received clinical supervision and safeguarding supervision which they told us they found helpful.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Health visiting staff attended weekly team meetings as well as meetings with teams from other areas of the borough. Family nurses had weekly meetings and supervision with their supervisor, who shared learning from senior management meetings with the team.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff said managers were very supportive of development and training opportunities were available, but some staff said finding the time for these was challenging.

The Healthy Weight Healthy Nutrition and Baby Friendly Initiative team is a borough-based 0-19 child healthy weight pathway within the Tower Hamlets GP Care Group linked with other organisations. The team provided training to staff to improve their practices, such as in how to hold conversations with parents on safer sleep and safer bed sharing. They also sent this information to GPs so professionals could provide families with consistent messaging. This team also promoted culture competency training to staff which raised awareness of different cultures.

New family nurses attended a week's foundation training run by the FNP National Unit who are responsible for the overall quality of the FNP services. The unit then provided new staff with additional input for the following year. Family nurses learnt skills such as communicating with children and families and motivational interviewing.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care usually worked together as a team to benefit children and their families. They supported each other to provide good care and communicated effectively with other agencies. However, staff did not consistently share all risks with other professionals.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. On the care records we looked at, we saw evidence of staff communicating and sharing information appropriately with GPs, housing officers, midwives, social workers and attending multi-agency meetings. Family nurses told us they also had links to Children and Adolescent Mental Health Services (CAMHS), perinatal mental health specialist teams and sexual health services. Representatives from the provider's child safeguarding team attended some of the higher risk meetings.

We found good practice examples; one record showed the family nurse had contacted the expectant mother's midwife on multiple occasions to inform them about concerns. As a result, the midwife and family nurse carried out a joint visit which led to a referral to a consultant for help with weight management.

Community health services for children, young people and families

Good

Staff were linked to local GP practices and attended multi-agency meetings where they shared information about vulnerable families. However, the frequency of these meetings and the consistency of risk sharing varied between staff members and GP surgeries. For example, one record we reviewed contained no evidence of information sharing with GPs for a child who was on an enhanced pathway of care. Senior leaders were aware of the inconsistencies with GP meetings and the sharing of information. They were in the process of reviewing the guidance and strengthening links with local GPs.

In a recent incident, 241 notifications from the local hospital's Emergency Department went to the health visiting service's junk mailbox and were unseen for four months. An investigation had taken place which considered the impact of this on each affected child and their family. The provider concluded there needed to be a review of notification processes between multi-disciplinary teams so these could be discussed and managed quickly.

Managers shared monthly updates with each other from internal and external partnership meetings. For example, one manager discussed plans to attend the Baby, Children & Young People North East London strategic meeting to look at recruitment and retention. The group discussed themes from a survey sent to Tower Hamlets staff about recruitment and retention.

Health promotion

Staff gave parents practical support and advice to lead healthier lives to benefit them and their children.

The service had relevant information available for parents which promoted healthy lifestyles and support options. Topics covered included diet, the impact of smoking and alcohol, sleep, and safety in the home. We saw one health visitor encouraged a mother to feed her 12-month-old solid foods after she identified he was mainly breastfed. The health visitor suggested suitable foods and provided information leaflets.

Several parents told us getting free vitamins was a helpful part of the service. We observed staff informing parents about these during appointments.

Consent and Mental Capacity Act

Staff provided families with information so they could make informed choices about care and treatment.

Staff clearly recorded consent in the children and parent records. We observed staff seeking consent from parents before they examined their children, and records detailed if parents consented to information sharing with third parties. However, one manager told us consent was generally implied as families were invited to attend or would make contact to request appointments.

Staff received mandatory training on the Mental Capacity Act. At the time of our inspection, the health visiting team was 96% compliant with this and the FNP team was 100% compliant.

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

Good

Compassionate Care

Community health services for children, young people and families

Good

Staff treated children and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff were passionate about delivering care to children and families.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Parents we spoke with said staff treated them well and with kindness. We observed family nurses and health visiting staff speaking kindly and respectfully to children and families during home visits and during appointments at the children's centres.

Staff followed the provider's policy to keep care and treatment confidential. There were separate rooms available in children's centres if parents wanted to speak with staff in private.

Staff understood and respected the individual needs of each child or young person and their families and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs or sensitive physical health needs. For example, one new mother wanted to discuss gynaecological issues. The member of staff confirmed the mother was comfortable discussing the matter in front of her partner and spoke discreetly so others could not hear.

All parents we spoke with were very satisfied with the care they received from the Family Nurse Partnership (FNP) and health visiting services. We spoke with 10 parents and they told us staff were very supportive and helpful. All staff spoke passionately about their roles and helping children and families.

Emotional support

Staff provided emotional support to families to minimise their distress. They understood the personal, cultural and religious needs of children and families.

Staff gave children and their families help, emotional support and advice when they needed it. We observed a health visitor providing compassionate emotional support to a recently bereaved family.

Some parents we spoke with said discussions with healthcare professionals covered their own wellbeing as well as their child's. The service had oversight of how many mothers had received a maternal mood review. Over a 12-month period, of those eligible for a maternal mood review, an average of 75% of mothers received one.

Staff provided their contact details to families so they could access support if required. All the families we spoke with told us their appointments were usually on time.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. For example, one mother said her health visitor had understood her culture and that she needed to rest for 40 days after giving birth.

Understanding and involvement of children and those close to them

Staff supported and involved families to understand their own needs and the needs of their children, and to make decisions about their care and treatment.

Community health services for children, young people and families

Good

Staff made sure families understood their care and treatment. Staff were knowledgeable and we saw them take time to ask questions about the children, their development and the parents' wellbeing. Staff provided verbal and written advice to parents. For example, advice on safer sleeping, immunisations and safety within the home.

Staff talked with children and their families in a way they could understand, using communication aids where necessary. For example, staff had access to interpreters and British Sign Language services if required and the service used the language skills of its diverse staff team to good effect. We saw evidence of interpreters being involved in home visits from notes in care records. However, some staff said finding consistently good and reliable interpreters was challenging at times.

Staff signposted families to other services and provided information such as advice on weaning, access to vitamins, and timetables for group activities at children's centres. All the parents we spoke with said they felt involved in their child's care.

Are Community health services for children, young people and families responsive?

Good

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to meet the changing needs of the local population. They regularly met with commissioners to discuss performance against targets and improvements they needed to make.

Staff met families at their homes, in the community or at children's centres. The location varied according to the child or family's needs or the focus of the appointment. Staff made reasonable adjustments when this was required.

Although Tower Hamlets is a diverse area, the service did not always have information leaflets available in languages spoken by the children, their families and local community. All the leaflets we saw displayed in local children's centres were written in English.

Meeting the needs of people in vulnerable circumstances

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children and their families access services. They coordinated care with other services and providers.

Staff supported children living with complex health care needs. For example, we saw a care record of a child with a genetic condition where the health visitor had downloaded a growth chart designed for children with this condition. They also communicated with the child's GP to share relevant information. The service was providing training on autism to staff during the time of our inspection and they were waiting for training on learning disabilities. This was in line with the requirements of the Health and Care Act 2022.

Community health services for children, young people and families

Good

The Healthy Weight Healthy Nutrition and Baby Friendly Initiative team had developed a directory of healthy weight support services for children aged between 0 and 19. At the time of our inspection this was due to be published. It aimed to provide professionals with information on a wide range of available services and would also be available to families on the Tower Hamlets GP Care Group website. We saw positive feedback from professionals about the directory.

The service helped parents with their individual needs. For example, we looked at a care record which showed a family nurse had helped a mother secure permanent housing before her baby was born. They worked closely with other professionals, including the midwife and housing officer, to provide support to this mother. The family nurse had also started to help her access a college course she was interested in. Staff applied for grants from a charitable organisation so disadvantaged parents could get shopping vouchers. The family nurses had access to easy-read pregnancy guides for women with learning disabilities.

Access to the right care at the right time

People could not always access the service when they needed it and did not always receive care in a timely way. Managers prioritised new birth visits to help identify children at risk.

The health visiting service did not always meet performance targets. Due to staffing issues, they were unable to consistently offer the mandated milestone checks outlined in the Healthy Child Programme. The senior leaders and commissioners were aware of this problem and had a plan in place to increase the number of children and families seen for their reviews. They also prioritised new birth visits to help identify children at risk.

The service had referral arrangements in place for children transferring between services. The service was implementing a Single Point of Access, which GPs and other healthcare professionals could refer to. There was a system in place with the Child Health Information System (CHIS) which monitored databases to identify families who had moved into the area. The service had systems in place to guide staff on how to respond in the event a family in vulnerable circumstances moved out of the area, including who they should notify.

Administration staff were responsible for updating allocation spreadsheets each day and sending them to the clinical managers of each team. At the time of our inspection, one team was piloting a new method for allocations via the electronic records system. This would end reliance on a separate spreadsheet. Senior leaders were aware of the inconsistencies in working practices and said a key area of their transformation programme was to ensure a standardised approach across teams. They also said the new systems would be able to generate a report on allocated and unallocated cases.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The provider's website included information on how to make a complaint. The provider had a system in place to review complaints and respond to them. In 2021 the health visiting service received six formal complaints. During the inspection we reviewed two complaints and found both had been fully investigated, apologies were given, and learning was identified. Managers investigated complaints and identified themes. They shared feedback from complaints with staff and learning was used to improve the service.

Community health services for children, young people and families

Good

Families we spoke with told us that they felt confident to raise any concerns directly with the service, but most told us they did not know how to make a complaint. Of the parents we spoke with, only those who accessed the FNP service were aware of how to complain. None of the parents we spoke with said they wanted to raise a concern about the service. We looked at the service's data for May 2022 and saw there had been no complaints and four compliments.

In addition, administration staff routinely contacted families via telephone to complete surveys and obtain feedback. The results were shared with senior leaders and actions and ideas for improvements were discussed during meetings with the senior management team. Managers planned to start a separate patient experience meeting to progress work.

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

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership team for 0 – 19 services had been in place for less than a year. They had clear plans for how to develop the service and were in the process of implementing a transformation programme to deliver improvements.

Leaders knew about most of the risks that we identified during the inspection and had plans in place to address them.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Tower Hamlets GP Care Group had six values and behaviours in place. These were:

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

Managers had a clear vision for the service. They were in the process of implementing their transformation programme. This involved changing the skill mix of staff within the health visiting service to meet performance targets.

The service had a clear mission which was, "to improve the health and wellbeing of residents by providing excellent primary and community care in partnership with others."

Community health services for children, young people and families

Good

The service worked closely with other local stakeholders in the wider health economy. Tower Hamlets GP Care Group was one of the six organisations that formed Tower Hamlets Together. This is the borough's health partnership that brings hospital, community health, mental health, adult and children's social services, public health, and the voluntary sector together.

Culture

Staff felt respected, supported and valued. They were focused on the needs of children and families receiving care. The service promoted equality and diversity in daily work, and it provided opportunities for career development. The service had an open culture where families and staff could raise concerns without fear.

Staff described the provider as supportive, flexible and encouraging of professional development. One member of staff was, for example, given time to study for a master's course relevant to their role. Other staff told us they were supported to go on training courses they were interested in. However, some staff said finding the time for additional courses was challenging.

Staff told us managers were supportive, encouraged them to develop and there was an open culture. For example, student health visitors told us the provider enabled them to stay within the service by giving them a role without an interview if they passed their courses. They said this was encouraging and compared this favourably to other employers who could not give this guarantee. Senior leaders told us about their 'grow our own' initiative. They planned to increase the number of student health visitors they accepted each year from four to six.

Some staff from the health visiting service told us they felt stressed because their workloads were unmanageable. However, all staff told us their managers were supportive and there was a positive culture within the service and teams. Staff felt comfortable raising concerns with managers. We were told managers had visited children and families, held clinics, and taken on caseloads of families in vulnerable circumstances to try and reduce some of the pressures staff felt. Staff who required it were given compassionate leave and extended time away from work during the pandemic.

None of the staff we spoke with reported any bullying or harassment. Most staff completed their mandatory training on equality and diversity and there was additional training available on unconscious bias and different cultures. Senior managers told us about ways they promoted equality and diversity. For example, one senior manager was starting a support group for colleagues with dyslexia, and another had written a publicly published blog about their experience in the workplace as a gay woman. There were Freedom to Speak Up leads across the service, although not all staff were aware of this.

Well-being support was available to staff with resources such as free counselling, advice on money issues, and schemes for train ticket loans. One member of staff had received coaching sessions they found helpful. There were also staff awards and social activities such as quizzes and a book club. Staff valued the well-being support offered by the provider.

Governance

Leaders operated governance processes throughout the service and with partner organisations that were effective most of the time. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Community health services for children, young people and families

Good

The service had clear governance structures in place. Senior leaders reviewed risks at the monthly Quality, Safety and Governance Committee, which reported to the provider's Board. This meeting included a review of performance data and safeguarding.

The service had a risk register. This identified risks in the service and included clear mitigations. The risk register was reviewed at the Quality, Safety and Governance Committee.

Senior staff were clear about their roles and accountabilities and had monthly meetings to discuss and learn from the performance of the service. Staff could complete incident forms and escalate concerns, and these were reviewed. We reviewed a sample of meeting minutes from the monthly Senior Management Team meetings and found topics such as the transformation programme, patient experiences and updates on projects were discussed.

The service had completed a deep dive review of health visiting services in November 2021. This had reviewed the risks in 0-19 services and considered what actions were needed to address them.

Managers were making changes to address problems. At the time of the inspection, the service was undertaking a transformation programme to make it better able to deliver services in the future. Managers were aware of most of the issues that we identified during the inspection and had plans to address them. However, governance processes had failed to identify that the provider's safeguarding policy was already out of date at the point of publication.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively, although a full record keeping audit had not been completed since 2020. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Leaders and teams used systems to identify and manage risk and performance but at the time of the inspection had not fully implemented the necessary changes. During the inspection, we identified concerns regarding the safeguarding policy, implementation of lone working, and the robustness of oversight systems. Leaders knew about most of the risks within the service and had plans to address them. For example, they were introducing a new case weighting tool which aimed to ensure caseloads took account of the complexity of some cases.

The service had not completed a full audit of record keeping notes since 2020, although managers reviewed records within their own teams. During the inspection, we found that records were not always completed fully. Health visitors had received record keeping training in 2021. Managers recognised the need for this training to be repeated and planned to conduct audits at least twice a year to improve the quality of records.

Information Management

The service collected data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. The information systems were integrated and secure. However, the service had experienced some issues with connectivity to the systems and a recent incident where notifications from the local hospital went to the junk email inbox.

The service had recently introduced a dashboard of performance information. This included their risk register, incidents and outcomes against targets. Managers used this data to make decisions and prioritise in order to improve the services.

Community health services for children, young people and families

Good

At the time of the inspection, some systems the service used did not always work robustly. For example, the vulnerable list document was not always updated by staff as expected and there was no back up if it was lost or corrupted. Senior leaders recognised they needed to implement further improvements in addition to those already in place. They planned to capture this information within their electronic patient record system in a way that enabled a report to be pulled from the system for monitoring purposes.

Between November 2021 and March 2022, there was an incident where referrals from the local Emergency Department were incorrectly allocated to the health visiting service's junk mailbox. The reason for this was found to be human error. This was identified and managers conducted a thorough review which resulted in an action plan and follow up with all children potentially impacted by the error.

Some staff reported challenges accessing the systems when they worked remotely. This caused delays in their work, although they said the IT department was very helpful. Staff were not always able to update their notes straight after appointments with children and families.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff told us they had been involved in ongoing conversations about changes, such as the plans for the service's estates and what was needed to improve service delivery.

The service had developed partnership working to improve services. For example, the service had developed links to voluntary sector organisations. One such organisation matched pregnant women with volunteers who could provide them with support.

Family views on the service were gathered by phone surveys. Senior managers discussed children and families' feedback during meetings. We saw evidence of feedback reports compiled in January 2022 and April 2022.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service was working with a local university on the Nurture Early for Optimal Nutrition (NEON) programme, a research project looking at growth of children in Asian communities.

The health visiting team was working towards the UNICEF Stage 3 Baby Friendly Initiative accreditation assessment which had been delayed due to Covid-19. The focus of this is to support breastfeeding and parent-infant relationships.

The service was looking at how it could link with other providers in the borough to adopt a trauma-informed approach to its work. They hoped that using this approach would improve the care they offered to parents.

Community health services for children, young people and families

Good

The service held quarterly learning forums where outcomes from patient feedback surveys were shared. Managers had noted some negative feedback from parents regarding rudeness from a few health visitors. In response, they planned to commission training to support staff with professional communication. They also requested patient details were recorded during feedback to enable follow up. Guest speakers were also invited to learning forums.

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
Maternity and midwifery services Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's safeguarding children policy and associated procedures do not accurately reflect current national guidance and are not relevant to the current provider.

Regulated activity	Regulation
Maternity and midwifery services Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider does not have robust systems in place to oversee and monitor the quality and safety of care provided to vulnerable children and families. The provider does not have robust guidance and practices around lone working.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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