North East Lincolnshire Council Children's Health Provision

Quality Report

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

Overall summary

North East Lincolnshire Council Children's Health Provision provides health visiting and school nursing services to children, young people and families in the Grimsby, Cleethorpes and Immingham area. They also provide an early intervention and prevention specialist service for families with children who have attention and behaviour difficulties.

We found the following areas of good practice:

Staff we spoke with were confident about safeguarding and knew what to do if they had a concern or needed to raise an alert. Children's Health Provision (CHP) worked closely with the Local Safeguarding Children Board (LSCB) and shared their safeguarding policies and protocols with other providers and partner agencies. Compliance with safeguarding children training and safeguarding supervision was good.

Vaccinations were safely stored with processes in place to maintain the cold chain during transportation and use. Health visitors were non-medical prescribers and we saw up to date Patient Group Directives (PGDs) for use by the school nursing service. Care records were completed accurately, in keeping with professional standards. We saw they were completed in a timely manner.

There were measures in place to protect staff who were lone working. Staff told us they followed lone worker guidelines and made local arrangements to ensure they were kept safe.

There were some good outcomes for Children's Health Provision who achieved a high overall participation rate of 99.3% in the National Child Measurement Programme (NCMP) and consistently good results in the immunisation programme.

Policies and procedures were in line with the National Institute for Health and Care Excellence (NICE) and national guidance. There was a process in place to monitor new guidance from NICE and cascade those relevant to service leads for action.

Summary of findings

The organisation had achieved level three accreditation with the UNICEF Baby Friendly Initiative. This is a global programme of the World Health Organisation and UNICEF, which encourages health services to improve the care provided to mothers and babies so they are able to start and continue breastfeeding for as long as they wish.

Staff were caring and offered emotional support to children, young people and families. Parents told us staff were very kind, understanding and helpful and we observed staff communicating with children, young people and their families in a respectful and considerate manner. Staff took time to explain things clearly and made time to answer questions. We received 92 comment cards from children, young people and families; 90 of these were positive and two had both negative and positive views. Comments about the Family Action Support Team (FAST) were exceptionally positive.

There was good access to services. The school nursing team had set up a duty phone line, which was staffed Monday to Friday from 12pm – 5pm. Staff were able to respond quickly to calls and escalate them to the appropriate school nurse if urgent. Clinics, support groups and drop in sessions were planned and provided at a variety of locations, across the geographical area to enable good access for families.

Interpreter services were available and staff could refer parents whose first language was not English for language lessons to support their integration into the local community. Staff were required to complete equality and diversity training. Information provided by the service showed compliance with this training was 100% for staff in the Family Action Support Team (FAST), 82% for school nurses and 76% for health visitors.

Health visitors told us they routinely undertook maternal mood assessments when they visited new mothers. School nurses used hospital passports for children with special needs.

Staff were aware of the vision and values of the service. They described the culture as open and they felt safe to own up if they made a mistake. Staff spoke positively about their line managers and service managers. They told us team leaders were visible, approachable and actively involved in the daily operation. However, some staff told us they did not feel confident about the leadership above this level.

The service was undergoing consultation on remodelling at the time of our visit. We found morale varied amongst staff groups and there was some anxiety about the outcome of the consultation and the new model of service delivery. Despite this anxiety, most staff were passionate about the services they delivered to children, young people and families.

We saw some good examples of innovation. For example, the school nurse text messaging service for young people and the parallel programme provided by the Family Action Support Team (FAST).

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

Although managers informed us there was an incident reporting culture and staff were encouraged to report incidents, we found clinical incident reporting was low and not consistent between all staff. Some staff were unclear what they should report as an incident and were therefore not reporting all incidents. We were concerned that incident reporting was low and the opportunity for learning and sharing from incidents could be missed.

Team leaders and the senior management team did not have oversight of staff compliance with mandatory training. Staff were not clear on which mandatory training they had completed and told us the systems for recording mandatory and statutory training were confusing and not easy to use. From information provided to us by the service, we could not be assured that staff were compliant with all mandatory training.

There were no infection prevention and control or hand hygiene audits taking place at the time of our inspection. Managers and team leaders told us they had identified an audit tool and this was in the process of being adapted for use in the service.

The voluntary redundancy of five whole time equivalent health visitors at the end of 2016 had affected service delivery. Due to the reduction in staffing capacity, the health visiting service was not able to deliver the full Healthy Child Programme (HCP). The service was only able to provide three out of the five key visits to all families with the remaining two visits being targeted at the most vulnerable children and families. Staff were concerned that this was a risk to children and families as issues may be missed.

Summary of findings

We found inconsistencies in staff receiving individual appraisals. Health visiting and school nursing staff we spoke with said they had not all received an appraisal in the last year. Staff in the Family Action Support Team (FAST) told us they received quarterly group supervision but had not had an individual appraisal for two years.

Although the service had processes in place to ensure risks were identified, monitored, managed and controlled through the corporate risk register; this did not fully align with risks we identified on inspection, for example, lack of oversight of mandatory training and staff appraisals.

We reviewed information during the inspection and could not find evidence the service had carried out necessary employment checks on directors of the service.

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

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Services we looked at: Community health services for children, young people and families

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Background to North East Lincolnshire Council Children's Health Provision

North East Lincolnshire Council Children's Health Provision provide services to children, young people and families in the Grimsby, Cleethorpes and Immingham area, with a population of approximately 160,000. The area has a high level of deprivation particularity within East Marsh, West Marsh and Southwards.

Services they provide include health visiting, school nursing, the Family Action Support Team (FAST) and they have a specialist team of safeguarding nurses.

Health visitors and school nurse teams are aligned to five family hub clusters. FAST is a small specialist team based at the William Molson Centre in Grimsby.

FAST provide an early intervention and prevention specialist service. They aim to meet the needs of families with children who have attention and behaviour difficulties often associated with autism, attention deficit hyperactivity disorder and other neurological conditions affecting social understanding, communication or global development.

Children's community health services were seconded to North East Lincolnshire Council in 2008, with the transfer of staff following in 2010.

At the time of our inspection, the service was undergoing consultation on a 0-19 programme service re-design. The consultation was due to be completed by 1 April 2017, with the aim for changes to be fully implemented by August 2017.

North East Lincolnshire Council Children's Health Provision was re-registered with the Care Quality Commission on 3 November 2014 to provide the service of caring for children (0-18 years) and the regulated activity of treatment of disease, disorder or injury.

The registered manager is Robert Ross.

The Care Quality Commission previously inspected North East Lincolnshire Council Children's Health Provision in November 2013 when all standards were met.

Our inspection team

Team leader: Alison Hudson (CQC Inspector)

The team that inspected this service comprised of two CQC inspectors and two specialists in health visiting and safeguarding.

Why we carried out this inspection

We inspected, but did not rate this service, as part of our ongoing comprehensive independent health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information we held about the location, asked a range of other organisations for information and sought feedback from patients. We held three focus groups to collect the views

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of staff working in the service. We analysed both organisation-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led.

We carried out an announced visit on 8 and 9 March 2017. We did not undertake an unannounced visit.

During the inspection visit, the inspection team:

- Visited two baby clinics, a school nurse drop-in clinic and an immunisation clinic
- Visited three patients in their own homes and spoke with 12 children, young people and families who were using the service
- Spoke with the registered manager and team leaders
- Spoke with 36 members of staff including school nurses, health visitors, family support workers and administration staff.

What people who use the service say

We spoke with 12 children, young people and families who had received care and we received consistently positive feedback about the care and treatment provided.

We received 92 comment cards from service users which were very positive. The comment cards from parents and children who had received services from the Family Action Support Team (FAST) were particularly positive.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Staff we spoke with were confident about safeguarding and knew what to do if they had a concern or needed to raise an alert. Children's Health Provision worked closely with the Local Safeguarding Children Board (LSCB) and shared their safeguarding policies and protocols with other providers and partner agencies. Compliance with safeguarding children training and safeguarding supervision was good.
- Vaccinations were safely stored with processes in place to maintain the cold chain during transportation and use. Health visitors were non-medical prescribers and the school nursing service used Patient Group Directives (PGDs) for a number of medications; for example, the morning after pill and vaccinations. A patient group directive allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. We observed several PGDs and saw they were signed and up to date.
- We reviewed 10 care records on the electronic system. Records included individualised care plans, risk assessments, action plans and relevant pathways. They were clearly set out, legible and comprehensive. Records were completed within 24 hours however, staff told us they often needed to do this at home in their own time.
- The baby clinic was visibly clean and tidy. We observed staff handwashing and using hand gel to clean their hands whilst adhering to the arms bare below the elbows guidance, in line with national good hygiene practice.
- All sets of baby scales we observed had been calibrated within the last year and were labelled with the date they were next due.

However;

- Team leaders and the senior management team did not have oversight of staff compliance with mandatory training. Staff were not clear on which mandatory training they had completed and told us the systems for recording mandatory and statutory training were confusing and not easy to use. From information provided to us by the service, we could not be assured that staff were compliant with all mandatory training.
- Although managers informed us there was an incident reporting culture and staff were encouraged to report incidents,

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we found clinical incident reporting was low and not consistent between all staff. Some staff were unclear what they should report as an incident and were therefore not reporting all incidents. We were concerned that incident reporting was low and the opportunity for learning and sharing from incidents could be missed.

- There were no infection prevention and control or hand hygiene audits taking place at the time of our inspection. Managers and team leaders told us they had identified an audit tool and this was in the process of being adapted for use in the service.
- The voluntary redundancy of five whole time equivalent health visitors at the end of 2016 had affected service delivery. Due to the reduction in staffing capacity, the health visiting service was not able to deliver the full Healthy Child Programme (HCP). The service was only able to provide three out of the five key visits to all families with the remaining two visits being targeted at the most vulnerable children and families. Staff were worried safeguarding concerns may go unnoticed and would not be addressed.

Are services effective?

- Policies and procedures were in line with the National Institute for Health and Care Excellence (NICE) and national guidance. There was a process in place to monitor new guidance from NICE and cascade those relevant to service leads for action. Any that resulted in a change in practice were added to the annual audit calendar to ensure compliance.
- Children's Health Provision (CHP) had an annual audit programme, which included vaccine storage and handling, interpretation service and breastfeeding training. This was monitored through the clinical governance provider group.
- The organisation had achieved level three accreditation with the UNICEF Baby Friendly Initiative. This is a global programme of the World Health Organisation and UNICEF, which encourages health services to improve the care provided to mothers and babies so they are able to start and continue breastfeeding for as long as they wish.
- We observed health visitors asking for verbal consent during home visits and baby clinics. Parental consent was gained prior to immunisation clinics and each child was asked for verbal consent prior to administering the vaccination. Health visitors and school nurses we spoke with understood the Fraser guidelines and Gillick competency test.

Summary of this inspection

- Health visitors reported very good relationships with local GPs and with children's therapy services. In order to promote and improve multi-disciplinary working, health visitors were located in family hubs, which included police officers, young people's services, counselling services, social workers, family resource workers and community midwives.
- There were some good outcomes for Children's Health Provision (CHP) who achieved a high overall participation rate of 99.3% in the National Child Measurement Programme (NCMP) and consistently good results in the immunisation programme.

However;

- The health visiting service was not able to deliver the full Healthy Child Programme (HCP) to all children and families. Due to staffing capacity, they delivered a targeted approach to two of the five health visiting contacts.
- We found inconsistencies in staff receiving individual appraisals. Health visiting and school nursing staff we spoke with said they had not all received an appraisal in the last year. Staff in the Family Action Support Team (FAST) told us they received quarterly group supervision but had not had an individual appraisal for two years. The team leader had raised this as an issue with the head of service who was developing an appraisal process across CHP services. We did not receive information on appraisal compliance rates from the provider.

Are services caring?

- Parents told us staff were very kind, understanding and helpful.
- We observed staff communicating with children, young people and their families in a respectful and considerate manner. Staff took time to explain things clearly and made time to answer questions.
- We saw school nurses carrying out a vaccination clinic at a school for children with special needs were very caring and patient. They ensured the process was quick and not too distressing for each child.
- Parents spoke very positively about the emotional support they received from health visitors.
- We received 92 comment cards from children, young people and families, 90 of these were positive, and two had both negative and positive views. Comments for the Family Action Support Team (FAST) were exceptionally positive. Comments included, 'all the staff have gone above and beyond to help my personal situation' and 'I honestly can't praise this service enough'.

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Are services responsive?

- Children's Health Provision (CHP) was undergoing consultation to remodel their services to meet the needs of the 0-19 programme, which aimed to reshape the whole children's service system to meet the needs of the local population.
- Clinics, support groups and drop in sessions were planned and provided at a variety of locations, across the geographical area within doctor's surgeries, health centres and schools, to enable good access for families.
- Health visitors told us they routinely undertook maternal mood assessments when they visited new mothers. School nurses used hospital passports for children with special needs.
- There was good access to school nursing services. The school nursing team had set up a duty line, which was staffed Monday to Friday from 12pm – 5pm. Staff were able to responded quickly to calls and escalate them to the appropriate school nurse if urgent.
- The school nursing team had introduced a new texting service for 11-16 year olds called 'ChatHealth'. A pocket-sized card with the text number had been circulated to children in secondary schools. School nurses could view the texts, respond quickly to requests for advice, and help on a number of issues including bullying, self-harm, smoking and mental health.
- Interpreter services were available and staff could refer parents whose first language was not English for English language lessons to support their integration into the local community.
- Staff were required to complete equality and diversity training. Information provided by the service showed compliance with this training was 100% for staff in the Family Action Support Team (FAST), 82% for school nurses and 76% for health visitors.
- The baby clinics we observed were bright, tidy and welcoming. Notice boards on the walls displayed useful information for parents.
- The service received one formal complaint in the 12 month period prior to 9 December 2016. This complaint was in relation to the health visiting service. Staff told us they tried to resolve concerns and complaints before they escalated. Compliments and concerns about the service were recorded on a log and shared with staff at monthly team meetings.

However;

- Staff working in the Family Action Support Team (FAST) told us waiting times had increased because senior managers instructed them to put their waiting list on hold until further notice. Two weeks prior to our inspection visit, they had been

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told to reopen the waiting list and had accepted 34 new referrals onto the list. The provider informed us that the waiting list contained a high proportion of inappropriate referrals which also contributed to the delay.
- Data submitted by the provider prior to inspection showed there were 32 referrals still waiting for assessment by the FAST. The mean number of days from referral to initial assessment was 126 and from initial assessment to treatment 32 days.

Are services well-led?

- Children's Health Provision strategy (across the 0-19 age range) aimed to create stronger communities and the strategic framework was composed of five principles: health and well-being; economic; prevention and early help; finance and safeguarding.
- Senior managers told us the six Cs of care, compassion, competence, communication, courage and commitment, were fundamental to their values. Staff we spoke with were aware of the six Cs and the vision and values of North East Lincolnshire Council Children's Health Provision.
- Staff spoke positively about their line managers and service managers. They told us team leaders were visible, approachable and actively involved in the daily operation. However, some staff told us they did not feel confident about the leadership above this level and felt the head of service did not fully understand the services they provided.
- We found measures were in place to protect staff who were lone working. Staff told us they followed lone worker guidelines and made local arrangements to ensure they were kept safe.
- Morale varied amongst staff groups and there was some anxiety about the outcome of the consultation on the new model of service delivery.
- Staff described the culture as open and staff felt safe to own up if they had made a mistake.
- We saw some good examples of innovation.

However;

- Although the service had processes in place to ensure risks were identified, monitored, managed and controlled through the corporate risk register; this did not fully align with risks we identified on inspection, for example, lack of oversight of mandatory training and staff appraisals.
- We had concerns that the leadership team did not have full oversight of risk and the quality management of the service. They had not identified all risks and did not have concerns about low incident reporting in the services they provided.

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- We reviewed information during the inspection and could not find evidence the service had carried out necessary employment checks on directors of the service.

Community health services for children, young people and families

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Incident reporting, learning and improvement

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. No never events had been reported in this service.
- The CQC received no notifications in relation to safety incidents for Children's Health Provision (CHP) in the last 12 months.
- There were no serious incidents requiring investigation, reported in the last 12 months within this service.
- Incidents were reported on an electronic reporting system. Staff could describe the incident reporting process and explained that their team leader was notified of all incidents via email.
- Between 1 January 2016 and 1 October 2016 there were 62 incidents reported by this service. The most reported type of incident was data entry by external agency (45), data entry by internal agency (six) and human error (three).
- The service followed the 'Clinical Incident Reporting Guidelines' (due for review May 2017) and the 'Management of Serious Incidents Guidelines' (under review at the time of our inspection) for North East Lincolnshire Council.
- Although managers informed us there was an incident reporting culture and staff were encouraged to report incidents, we found incident reporting was not consistent between all staff. Some staff were unclear what they should report as an incident and were therefore not reporting all incidents.
- Some staff were able to give us examples of incidents they had reported, whilst others told us they preferred to escalate issues through their line manager rather than reporting them as an incident. Staff said they always reported incidents of staff abuse by service users, however, we did not find any incidents of this nature had been reported.
- Staff told us they normally received feedback from incidents and they provided several examples of learning and action taken because of incident reporting. One example was when several incidents had been reported relating to a lack of communication between midwives and health visitors. Managers identified this as a trend and the service took appropriate action to raise this with the midwifery team in order to improve communication.
- Staff were able to give examples of learning which occurred following an incident. An incident occurred when a child had been vaccinated twice in error. The reason for this was the first vaccination had not been recorded in the correct section of the patient's electronic record. Because of this, staff were given additional training on recording vaccinations on the electronic system so it was clear to all staff viewing the record.
- A team leader told us incidents were discussed at team leader meetings, and shared with staff at staff meetings. Staff told us these meetings had not always been regular but were currently taking place every two weeks. We saw copies of the minutes and incidents were a standard item on the agenda.
- The clinical compliance and quality lead told us they analysed all incidents to identify themes and trends. Incidents were discussed at quarterly governance meetings and if necessary a task and finish group would be set up to address the underlying issues.

- Incidents were sent to the most appropriate person to investigate. The health visiting service manager told us she had completed Root Cause Analysis (RCA) training last year.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Most staff we spoke with understood the principles of duty of candour and the importance of being open and honest with patients when mistakes were made. A school nurse was able to give an example of when duty of candour had been applied.

Safeguarding

- The CQC received no safeguarding alerts or concerns in relation to North East Lincolnshire Council Children's Health Provision in the last 12 months, as at 16 December 2016.
- CHP had a named nurse for safeguarding children and a team of three specialist nurses.
- There were good links with other agencies. The service had links with other agencies such as children's social services and the local women's aid centre. A dedicated health visitor visited the centre to support the families who lived there. The service also kept track of the children who left the women and children's refuge centre so they could continue to offer care and support.
- Staff we spoke with were confident about safeguarding and knew what to do if they had a concern or needed to raise an alert.
- CHP worked closely with the Local Safeguarding Children Board (LSCB). They shared their safeguarding policies and protocols with other providers and partner agencies.
- The safeguarding team carried out regular LSCB audits and we saw the findings were shared with service managers. The LSCB Annual Report 2015-2016, found no areas of significant concern with studies of partner agencies. The report recommended a general area of development for all organisations, which was the level to which they could evidence that service development was informed by the views of children and families.
- Safeguarding policies and procedures were in place and there were guidelines for staff to follow should a child fail to attend an appointment or a member of staff fail to gain access to see a child in the family home.
- The named nurse for safeguarding told us the service had produced an action plan, which fed into the overarching LSCB plan. This identified all current priorities, which included learning from Serious Case Reviews (SCRs) and incorporated audit activity.
- Staff received regular quarterly safeguarding supervision in line with the organisational policy. They told us the quality of supervision was good. Staff with caseloads could request additional supervision if needed. There was a team of trained supervisors across the health visiting and school nursing teams
- The named nurse for safeguarding monitored compliance with supervision monthly, against a target of 95%. Information provided by CHP for 2016/2017, showed in quarter one, 90% of health visitors and school nurses received supervision, 96% in quarter two and 84% in quarter three. We were informed that the reason for the drop in quarter three was due to the impact of staff leaving following voluntary redundancy and significant staff sickness leading to a reduction in supervisors. In response to this,11 further supervisors had been trained in November 2016 to replace those who had left.
- Although supervision was good overall, the named nurse wanted to ensure staff brought the right cases to supervision sessions. The nurse was developing guidance for staff, which identified specific criteria, for example the level of complexity.
- New staff and staff returning from maternity leave or a long absence, received supervision directly from the safeguarding team every eight weeks throughout their first year. A member of the safeguarding team would also accompany them if they attended any case reviews. This practice was in response to an incident reported by a health visitor, who said they had not received much training in safeguarding cases when studying at university.
- Staff shared with us examples of learning from safeguarding. There had been a review of baby deaths by the Child Death Overview Panel (CDOP). Because of this, all agencies reviewed their sleeping safe protocol and strengthened their information and processes.
- Health visitors told us the criteria for referring safeguarding concerns to the Family First Access Point (FAPP) had changed. Staff now had to prove there was a specific risk to the child, not just key indicators. Staff

told us they felt this made the process more difficult and there was a greater emphasis on early help. Staff also told us it could be difficult to contact the safeguarding children team for support and advice.

- If the FAPP decided a health visitor needed to deliver more early help to a family, the issue was escalated to a multi-disciplinary meeting, chaired by the family hub cluster co-ordinator. Health visitors were concerned this process led to delays in providing timely support for vulnerable children.
- Staff were aware of learning from Serious Case Reviews (SCRs). The safeguarding named nurse had held workshops with staff in relation to SCRs in order to share learning and key messages. A workshop on domestic violence had been held recently. Staff said workshops were usually held monthly. Outside speakers were sometimes invited, for example, an advocate from the Women's Aid shelter, the community dentistry team, and the Children and Adolescent Mental Health Service.
- Specialist nurses for safeguarding children told us they were able to work at different locations and be visible and available to support staff. They attended team meetings and accompanied the police on all initial safeguarding meetings, where appropriate.
- Staff were aware of and understood Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM). Staff attended 'Prevent' and FGM training as part of their mandatory training.
- All CHP staff attended safeguarding children training; the level of training required was dependant on their role. Information provided by CHP showed good compliance with safeguarding training. School nurses (level three), safeguarding specialist nurses (level three/four) and staff in FAST (level two/three) all achieved 100% compliance. Health visitors (level three) achieved 92% compliance and administration staff (level one) 79% compliance.
- Staff told us they covered adult safeguarding training during the child safeguarding sessions they attended. Information supplied by the provider indicated that staff had not received specific adult safeguarding training and this was included within the 2017-2108 training programme.

Medicines

- The service had 34 health visitors who were non-medical prescribers. Health visitors carried their own prescription pads and new pads were kept locked away at the William Molson Centre. A 'Non-Medical Prescribing Policy' was in place.
- An anaphylaxis shock pack, which contained adrenaline, was available for all immunisation clinics. We examined a pack and saw it was sealed, tagged and in date.
- Patient Group Directives (PGDs) were in place for the school nursing service for a number of medications, for example, the morning after pill and vaccinations. A PGD allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. School nurses carried a copy of the PGDs with them. We observed several PGDs and saw they were signed and up to date.
- Vaccinations were stored in fridges within a secure central storeroom. Fridge temperatures were checked daily to ensure they remained within the correct temperature range. There was a spare fridge available and a back-up generator in case of power failure.
- To maintain the cold chain, vaccinations were transported from the storage fridges to clinics using a vaccine carrier system. The carriers maintained a temperature of between +2°C and +8°C.
- We observed staff check the expiry date of the vaccination prior to administration and this was recorded in the patient's record with the batch number, date, time and which arm into which it was injected. All children were given an information leaflet for parents, following their vaccination.
- CHP had a medicines management contract through a service level agreement with another provider. This included a pharmacist and a medical officer who annually reviewed and approved the PGDs. They also provided staff with annual clinical updates. Staff were able to contact the pharmacist or the medical officer if they needed advice related to PGDs or non-medical prescribing.
- We saw copies of standard operating procedures for medicines, including, the administration of injectable medicines, dealing with medicines incidents and the disposal of vaccines / medicines.

Environment and equipment

- Baby scales were calibrated annually. All sets of baby scales we observed had been calibrated within the last year and were labelled with the date they were next due.
- Health visitors told us they had enough equipment to deliver safe care and had no problems ordering equipment.
- The Family Action Support Team (FAST) provided services from shared facilities within the William Molson Centre. There was a separate entrance and reception area for children and families with disabled toilet facilities. We observed a parent's room, a breakout room, a large playroom and a kitchen area for the provision of drinks and snacks. The rooms were well organised and welcoming for children and parents.
- All staff had mobile phones and the majority had their own laptops. Those who did not have laptops told us they were currently in the process of being ordered.

Quality of records

- Children and young people's records including health care plans, were held on an electronic records system. Children at special schools had an additional paper copy at the school.
- We reviewed 10 care records on the electronic system. Records included individualised care plans, risk assessments, action plans and relevant pathways. They were clearly set out, legible and comprehensive.
- Team leaders told us staff completed records within 24 hours but often had to work additional hours to do this. Staff at the focus group told us they often needed to work at home in their own time to ensure they completed patient's records in a timely manner.
- The service carried out regular record keeping audits. We saw the most recent audit report for 'Child Health Record Keeping 2016/17'. The audit gave satisfactory assurance and included detailed findings and an action plan for improvement.
- Team leaders told us they reviewed a sample of records at supervision sessions. Good practice identified from the reviews was shared at team meetings.
- All staff were required to complete data protection and information security training as part of their mandatory training. From the information provided by the service, it was not clear which staff had completed this training.

Cleanliness, infection control and hygiene

- The baby clinic was visibly very clean and tidy. We observed staff washing their hands and using hand gel between patients. Staff adhered to the arms bare below the elbows guidance, in line with national good hygiene practice. We also observed staff practice good hand hygiene within family homes.
- In the baby clinic, staff cleaned the equipment after every use using antibacterial cleaning wipes. Staff also used blue paper roll to line changing mats and baby scales between each use. We observed staff wiping toys clean at the beginning and the end of the session.
- We observed a school immunisation clinic during our visit. The room appeared clean and handwashing facilities were available. We observed the nurses using hand gel and changing gloves between patients, however, we did not see the nurses wash their hands with soap and water.
- We saw sharps and clinic waste were safely managed and disposed of in line with health and safety regulations. Sharps bins were correctly labelled and dated.
- CHP had an infection prevention and control policy in place. Staff were required to undergo annual infection control training, however, from the information provided by CHP it was not clear which staff had completed this training.
- Infection prevention and control advice and training was provided by another organisation through a service level agreement. CHP had recently reviewed their infection prevention and control arrangements and allocated a named infection prevention and control link person for each team. The link person was responsible for attending quarterly meetings and training with infection control advisors and feeding this information back to their teams.
- There were no infection prevention and control or hand hygiene audits taking place at the time of our inspection. Managers and team leaders told us they had identified an audit tool to use and this was in the process of being adapted for use in the service. Once the audit tool was ready for use, there was a plan to train staff.

Mandatory training

- Staff were required to complete a range of mandatory and statutory training, which included manual handling awareness training, fire safety training, infection

prevention and control training, data handling training, personal safety, safeguarding training and lone working awareness training. Training was available both face to face and online.

- There was no senior management oversight of staff compliance with mandatory training. There were two systems to record training, which led to difficulties in both recording and monitoring. The head of service acknowledged they did not have a robust method to monitor this and were in the process of looking for a system to record all training in one place.
- Team leaders told us they discussed mandatory training individually with staff during supervision, however, they did not all have oversight of the training completed by their team and which training was out of date.
- Staff at the focus group told us they were not clear on which mandatory training they had completed, what the actual requirements were and when it needed to be completed. Staff told us the systems for recording mandatory and statutory training were confusing and not easy to use.
- From information provided to us by the service, we could not be assured that staff were compliant with all mandatory training.

Assessing and responding to patient risk

- Health visitors told us they reviewed all GP, out of hours, and Accident and Emergency attendances to monitor the children on their caseload.
- Health visitor team leaders told us they reviewed workload and caseloads daily to ensure vulnerable children were prioritised.
- Single assessment meetings took place in every cluster every week or fortnight. They were attended by a multidisciplinary team, which included police, National Society for the Prevention of Cruelty to Children, school nurses, teachers and health visitors. Staff told us each case was discussed in detail and mapped to determine the main issues, assess the risk and agree appropriate action to manage the risk.
- We found no issues in relation to the handover of children between health visitors and school nurses. The health visitor was able to add the child to the school nurse caseload on the electronic system. If the child was vulnerable, the health visitor would complete an electronic template and have a face to face meeting with the school nurse. If deemed appropriate they would both attend the case conference meeting.
- Patient risks and issues were clearly documented in their electronic records. For example, we saw that a peanut allergy was documented in one child's records with a plan of what to do if this occurred.
- Health visitors told us that if they felt they were not able to meet the needs of their patients they would escalate this to their team leader who in turn would escalate this to the service manager and head of service.
- Health visitors were able to check each other's tasks on the electronic records system and provide cover for urgent issues if their colleagues were off sick or on annual leave.
- On the day prior to an immunisation clinic, school nurses checked patient records on the electronic system to ensure they had not already received the vaccination from another health care professional. This was to avoid giving a double dose.
- The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. There was a process in place for checking and cascading CAS alerts. Any relevant to the service were circulated to the appropriate service leads who completed an action plan.

Staffing levels and caseload

- Children's Health Provision employed approximately 85 whole time equivalent (wte) staff; 111 people in total. There were 34.5 wte health visitors and 21.5 wte school nurses.
- Health visitors told us they had been successful in recruiting and training a full establishment of staff following the 'Call to Action' campaign. However, the voluntary redundancy of five wte health visitors at the end of 2016 had an impact on service delivery. The service's capacity to deliver the full Healthy Child Programme (HCP) was affected, as not all families received the five key visits. Two of the key visits were targeted at the most vulnerable children and families only.
- There were five health visiting teams, aligned to five family hub clusters. Information provided by the service showed that on average, each whole time equivalent health visitor had a caseload of approximately 305 children. Each caseload included vulnerable children on protection plans, safeguarding and early help.

Caseloads were adjusted, depending on level of deprivation and the number of child protection and safeguarding cases. Staff told us the voluntary redundancies in 2016 resulted in an increase in workload for the rest of the team.

- Health visitors were concerned about the lack of skill mix in the teams. Although nursery nurses still assisted health visitors at baby clinics, they were no longer part of the service. Nursery nurses had moved from the health visiting team and were now employed as family hub advisors. If a health visitor required the support of a family hub advisor, they had to make a referral. Health visitors said this caused a delay and meant families did not always receive timely support.
- The school nursing service was divided into two teams. One team was aligned to clusters two and three, and the other team to clusters one, four and five. The school nurse team leader for clusters two and three had no vacancies. The school nurse team leader told us that when staff left, the vacancies had been lost to efficiency savings. The team leaders did not have their own caseload but provided cover for other staff when needed, for example to cover training or sickness.
- School nurses were allocated a caseload of primary and secondary schools. Caseloads were reviewed yearly and took into account the number of ongoing safeguarding cases; however, they tried to keep the same schools for consistency and to promote relationship building. Information provided by the service showed on average, each whole time equivalent school nurse had a caseload of approximately 1390 children.
- There were six staff (4.3 wte) in the Family Action Support Team (FAST). There was a team leader, two practitioners and three support staff. Staff told us the team had decreased considerably in size due to redundancy and staff leaving and not being replaced. Staff told us they had to prioritise what they provided and they sometimes needed to cancel programme sessions if a member of staff was off sick. Cancellation of sessions was a last resort and only done if the staff did not have correct ratios for working with challenging children. This was for the safety of both the children attending group and the staff.
- Children's Health Provision (CHP) did not use any bank or agency staff. Staff turnover for the financial year 2016/17 up until 9 December 2016 was 13.7% for health visitors and 0% for school nurses and staff in the FAST.

Managing anticipated risk

- North East Lincolnshire Council kept a record of potentially challenging or violent individuals who posed a threat to employees. This information was recorded in the form of a 'Cautionary Contact' list and shared amongst staff in the CHP service who needed to know. Line managers were able to access this information and share it with practitioners.

Major incident awareness and training

- A 'Business Continuity Plan' for the service was in place. The plan identified critical functions and the minimum level of service required to provide critical functions, in the event of a disruption in normal business.
- Staff did not complete major incident training as part of their mandatory training however, they were aware of the business continuity plans.

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

(for example, treatment is effective)

Evidence based care and treatment

- Policies and procedures were in line with the National Institute for Health and Care Excellence (NICE) and national guidance. There was a process in place to monitor new guidance from NICE and cascade those relevant to service leads for action. Any that resulted in a change in practice were added to the annual audit calendar to ensure compliance.
- The service followed evidenced based programmes, for example the National Child Measurement Programme (NCMP) and the Healthy Child Programme (HCP).
- Health visitors used Ages and Stages Questionnaires (ASQs) as part of their assessment of children. This is an evidence-based tool to identify a child's developmental progress, readiness for school and provide support to parents in areas of need.
- Staff told us they had access to policies and these were stored on the organisation's intranet. We reviewed several polices, for example the 'Medicines Policy for Registered Healthcare Professionals' and ' Infection Prevention and Control Policy' The policies we reviewed were all within their review date.

- Policies and guidelines were reviewed at team meetings. One team leader had recently updated the reflux policy, shared this with the team, and invited comments on the draft policy.
- Children's Health Provision had an annual audit programme, which included vaccine storage and handling, interpretation service and breastfeeding training. This was monitored through the clinical governance provider group.
- The Family Action Support Team (FAST) used the principles of the 'Triple P – Positive Parenting Program', in their sessions with parents and children. Triple P is an evidence based parenting programme, which gives parents simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behaviour and prevent problems developing.
- Staff in FAST followed agreed guidelines for behaviour management. Restraint was sometimes necessary in order to protect a child or young person or others from harm. They used ''Team Teach' strategies of de-escalation to reduce risk and the need for restraint when challenging behaviour arose. Incidents of holding children whilst accessing the FAST service were audited yearly. Staff reported that in the last year they had only needed to use restraint of a child once.

Nutrition and hydration

- Health visitors provided information and support for children with complex feeding needs and worked closely with the speech and language therapy service. Health visitors told us they were able to contact the service about a child who had feeding problems and arrange an appointment for a swallow assessment for the next week.
- The organisation had achieved level three accreditation with the UNICEF Baby Friendly Initiative. This is a global programme of the World Health Organisation and UNICEF, which encourages health services to improve the care provided to mothers and babies so they are able to start and continue breastfeeding for as long as they wish.
- Children's Health Provision (CHP) provided breastfeeding peer supporters who usually attended baby clinics to support new mothers with breastfeeding support and advice. During our inspection, we observed a breastfeeding peer support group taking place in the room next door to the baby clinic. Staff told us this useful as, if needed, they could offer additional advice and support.
- Health visitors told us breastfeeding had a high priority across the service. Specialist training was being rolled out to all health visitors and relevant information was included in the red child health record book.

Patient outcomes

- The Family Action Support Team (FAST) provided a parallel programme for children and parents. The team used the Strengths and Difficulties Questionnaire (SDQ) to measure outcomes of their interventions. SDQ is a brief behavioural screening questionnaire for children aged three to16 years. They also asked parents to evaluate the programme and used this information to review and make improvements to the service.
- The health visiting service delivered the Healthy Child Programme (HCP). The HCP focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. However, health visitors were not able deliver the full programme to all children and families. Staff and managers explained this was due to the staffing capacity and they delivered a targeted approach to the five health visiting contacts:
- The three universal contacts were the primary birth visit, the six to eight week check and the 12 month check. Team leaders told us they were delivering on all of these and all families received these visits.
- There were two targeted contacts - ante-natal and 27 months. Staff told us only the most vulnerable children and families received these visits. There were no Key Performance Indicators (KPIs) set for the delivery of these targeted contacts. A team leader told us one reason for this was due to the fact many children moved around the area and some could have as many as 10 different addresses in a year.
- Health visiting team leaders did not appear to have oversight of HCP outcomes or health visitor caseload numbers. Team leaders said there was no dashboard to record this data however the health visiting service manager told us they received quarterly data from the business support team. We reviewed this data for July to September 2016. For universal contacts, CHP achieved 62.4% for new birth visits before 14 days and 31.7% for

new birth visits after 14 days. The percentage of children who received a six to eight week check before eight weeks was 77.9% and 92.2% of children received the 12-month check before 12 months. For the targeted checks, the data gave the total number of antenatal contacts (295) and 85.9% of children received a 27 month review.

- Health visitors told us they made team leaders aware of their progress towards HCP outcomes at supervision sessions.
- The National Child Measurement Programme (NCMP) is a nationally mandated public health programme. It provides the data for the child excess weight indicators in the Public Health Outcomes Framework and is part of the government's approach to tackling child obesity. CHP achieved a high overall participation rate of 99.3% in the NCMP, which was better than the England average of 94.9%. The school nursing team offered intervention to children with a body mass index falling outside of healthy parameters.
- The immunisation programme achieved consistently good results. Data supplied by the service showed that for 2015/2016 the service exceeded national average levels of vaccination for four out the six vaccinations they performed and were very close to the national average in the remaining two. For school based immunisation programmes led by school nursing, this included children educated at home and those with alternative provision, who were sent a letter of invitation to attend accessible clinics across the area.

Competent staff

- Health visitors told us they had good opportunities to participate in additional training activities.
- Senior managers told us health visitors and school nurses had contributed to university programme modules and had attended lectures to speak with students. Managers also told us they encouraged practice development and two members of staff had successfully published work in a national health publication.
- The health visiting and school nursing services had practice teachers to support student health visitors and school nurses in their training. A student health visitor and student school nurse we spoke with told us they received excellent support and development from their practice teacher. They described the whole team as supportive and received regular formal and informal supervision.
- A school nursing team leader told us the service tried to grow their own staff. Several staff were qualified mentors and supported undergraduate student nurses on placement.
- There was an induction checklist and record for new staff joining Children's' Health Provision (CHP). Preceptorship guidelines were in place to support new staff.
- Staff told us they received supervision every three months, which was documented by their team leaders. This was in line with the CHP supervision and appraisal policy, which states 'quarterly supervision and annual appraisal is compulsory for all members of Children's Health'.
- We found inconsistencies in staff receiving individual appraisals. Health visiting and school nursing staff we spoke with said they had not all received an appraisal in the last year. Some staff said this was included in their quarterly supervision.
- Staff in the Family Action Support Team (FAST) told us they received quarterly group supervision but had not had an individual appraisal for two years. The team leader had raised this as an issue with the head of service who was developing an appraisal process across Children's Health Provision services. We did not receive information on appraisal compliance rates from the provider.
- We saw a copy of the 'Children's Health Supervision and Appraisal Policy' which was under review and consultation.
- Staff told us they felt well supported in achieving revalidation. School nurse and health visitor team leaders had oversight of the process.
- The health visitor service had specialist 'champion' roles. Health visitors had the opportunity to develop their interests and received appropriate training to support families and keep their colleagues up to date with current guidance, for example, breastfeeding champions, infection prevention and control champions and signs of safety champions.
- The school nursing team were receiving training in cognitive behavioural therapy (CBT) to promote healthy eating and provide a first line of support to children with

mental health issues. Junior school nurses were also undertaking the training to enable them to signpost children and young people to their colleagues or to other services.
- Staff working in FAST had additional postgraduate qualifications in attention deficit hyperactivity disorder (ADHD), autism spectrum conditions and training in cognitive behavioural therapy and systemic family therapy. Staff told us they had recently received training in attachment; however, they did not feel they had many opportunities for additional training.

Multi-disciplinary working and coordinated care pathways

- Services for children and young people worked together and with external agencies to assess, plan and co-ordinate the delivery of care.
- Staff described positive links with local MARAC (multi-agency risk assessment conference) and MASH (multi-agency safeguarding hub) committees. The Children's Health Provision had also recently developed the Families First Access Point (FFAP), which worked directly with MASH focusing specifically on early help and safeguarding.
- Health visitors reported very good relationships with local GPs and with children's therapy services.
- In order to promote and improve multi-disciplinary working, health visitors were located in family hubs, which included police officers, young people's services, counselling services, social workers, family resource workers and community midwives. Health visitors spoke positively about the strong links they had developed and said communication was excellent.
- School nurses were in the process of moving from their central office base to working in family hubs. Staff from cluster four were already working out of a hub. There were plans for cluster three to move out next.
- The Family Action Support Team (FAST) worked in partnership with other agencies for example the Child and Adolescence Mental Health Service (CAMHS), educational psychology, and schools. They also signposted parents and children to other services, for example, the young carers group which was provided by the youth service.
- School nurses told us they worked well with schools with other agencies and they felt there was joined up working. If they had concerns, they completed a Multi-agency Child Exploitation (MACE) assessment tool, which was shared with other agencies.

Referral, transfer, discharge and transition

- Health visitors told us they worked closely with school nurses to discuss vulnerable school-age children and ensure they shared important information. Children with special needs or those subject to a child protection plan were 'handed over' in a face-to-face discussion. Parents were involved in the handover if appropriate.
- The Family Action Support Team (FAST) received referrals from any agency working with children and these were triaged by the team. Staff told us the majority of referrals came from paediatricians, health visitors and school nurses. Paper referrals were sent direct to the service, however, a single point of access was being proposed as part of the restructure.
- School nurses were involved in meetings to discuss the transition of young people with special needs from child to adult services.

Access to information

- All services in the Children's Health Provision (CHP) recorded contacts and patient information on an electronic records system. This meant information could be shared across the services and teams. Health visitors told us they were able to send their colleagues tasks within the electronic system to alert them to potential issues with a child or family.
- Therapy services and the looked after children service used the same electronic records system. This meant information could be accessed easily and was readily available for health visitors and school nurses. GPs also used the same system (with the exception of four practices).

Consent

- We observed health visitors asking for verbal consent during home visits and baby clinics.
- Parental consent was gained prior to immunisation clinics and each child was asked for verbal consent prior to administering the vaccination.

Community health services for children, young people and families

- School nurses were clear on consent. Staff gave an example of when a child had been assessed without the prior consent of their parent. The member of staff had realised their error, reported this to their manager and telephoned the child's parents to explain.
- Health visitors and school nurses we spoke with understood the Fraser guidelines and Gillick competency. Fraser guidelines and Gillick competency must be considered when offering treatment to children less than 16 years old, to decide whether a child is mature enough to make decisions about their own care. We observed a school nurse drop-in clinic and saw that the school nurse followed a counselling framework for safer sex, which took account of the Fraser guidelines and Gillick competency when supplying young people less than 16 years of age with condoms.

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

Compassionate care

- Prior to the inspection, we contacted three parents by telephone to ask their views of this service. All parents were very happy with the services they had received and told us that staff were very understanding and helpful.
- We spoke with 12 children, young people and families who had received care from this service and all gave positive feedback about their care and treatment.
- Prior to and during this inspection we provided comments cards for parents and young people to tell us what they thought about this service. We received 92 comment cards; 90 were positive and two had both negative and positive views. Positive comments from parents and young people included, 'all staff were very helpful, welcoming and friendly', 'we are always treated with respect and dignity', 'fantastic service every visit' and 'staff are very caring and have time to listen'. The two negative statements were about receiving conflicting advice from health visitors and one parent thought there was limited support for complex feeding issues.
- We received 15 comment cards from parents and children who had received services from the Family Action Support Team (FAST). All were exceptionally positive. Comments included, 'all the staff have gone above and beyond to help my personal situation', 'I honestly can't praise this service enough', 'the past and present course has been invaluable in helping me to understand my son's behaviour' and 'the service had helped my child and myself massively'.
- We observed staff communicating with patients and their families in a respectful and considerate manner. Staff took time to explain things clearly and made time to answer questions.
- We saw school nurses carrying out a vaccination clinic at a school for children with special needs were very caring and patient. They ensured the process was quick and not too distressing for each child.
- We heard about a health visitor arranging nursery care for a toddler for two days each week to enable a mother to visit and care for her baby in the special care baby unit. The father worked full time and the family had no extended family to offer them support.

Understanding and involvement of patients and those close to them

- Parents we spoke with told us they were given relevant information and staff took the time to explain anything they did not understand.
- We observed good communication between school nurses and young people. An opportunity was given to ask questions or discuss any concerns. Staff appeared open and genuine and it was clear they had developed good relationships with the children and young people attending the clinic.
- We saw positive interactions between a health visitor mum, baby and sibling. The health visitor gave appropriate advice in relation to feeding and nutrition using the latest guidance.
- Staff told us they always put children and families at the heart of their care and actively recognised the voice of the child.

Emotional support

- One health visitor explained they always encouraged their families to attend clinic so they could connect with them and their colleagues on an emotional level. They told us they always tried to demonstrate positive behaviours and were non-judgemental, normalising concerns raised by parents so they did not feel uncomfortable or inadequate.

Community health services for children, young people and families

- One parent spoke very positively about the support they received from her health visitor when they were struggling because their child was not sleeping. The health visitor offered advice and support about sleep management.
- A health visitor went over and above their role to keep a distressed mother safe by ensuring she received the right support. The health visitor involved the local church, extended family and the community to help her. The health visitor then kept in very close contact with the mother and her child. The mother also visited the health visitor at the family hub and accessed additional support from the services available there.
- We observed a health visitor offering emotional support to a mother who appeared unhappy and angry with her partner at the baby clinic.
- School nurses offered a counselling session to young people prior to performing a pregnancy test.

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

Planning and delivering services which meet people's needs

- Children's Health Provision (CHP) worked closely with commissioners and other service providers to ensure they were meeting the needs of the local population.
- A service level agreement was in place with local commissioners. The informatics team provided data to the commissioners. Performance was discussed and if necessary challenged, at quarterly public health outcomes meetings.
- The 0-19 programme aimed to reshape the whole children's service system to meet the needs of the local population. CHP managers and staff were actively involved in the planning and delivery of this redesign programme, which involved working closely with colleagues within the organisation and with other agencies.
- Clinics, support groups and drop in sessions were planned and provided at a variety of locations, across the geographical area within doctor's surgeries, health centres and schools, to enable good access for families.
- School nurses ran drop-in clinics in secondary schools to allow easy access to advice and support for young people. They discussed issues such as depression, self-harming, stress, contraception, positive pregnancy tests, sexually transmitted infections, alcohol, drugs, puberty and bullying.

Equality and diversity

- Interpreter services were available for patients whose first language was not English. Staff told us there were no problems accessing this service. There was a facility on the provider's website to translate information for service users into 101 different languages. The school nursing service told us they were planning to develop their own information leaflets in other languages.
- Health visitors told us they could refer parents who first language was not English for English language lessons to support their integration into the local community.
- Health visitors had a good understanding of the diversity across their patch. They said there were a high proportion of Eastern European families, and a smaller population of Asian families. They told us they did not have any traveller families within their communities, although there were asylum-seekers.
- All of the locations we visited had disabled access.
- The baby clinics we observed were bright, tidy and welcoming. Notice boards on the walls displayed useful information for parents.
- Children' Health Provision (CHP) staff were required to complete equality and diversity training. Information provided by the service showed compliance with this training was 100% for staff in the Family Action Support Team (FAST), 82% for school nurses and 76% for health visitors.

Meeting the needs of people in vulnerable circumstances

- Children who were not yet registered at a school were offered support from the school nursing team. This included children of asylum seekers who had recently moved into the area.
- Health visitors supported children with complex needs through involvement with the Multi-agency Assessment Team (MAAT) process and community paediatricians.
- Health visitors told us they routinely undertook maternal mood assessments when they visited new mothers although we did not observe these in the

records we looked at. Staff were receiving perinatal mental health training and one health visitor was undertaking a masters degree and was focusing their studies in this area.

- School nurses used hospital passports for children with special needs. The passport used a traffic light system to communicate information about the child or young person. Urgent information such as allergies and medication were in the red section, other important information was in the amber section and likes/dislikes and preferences were in the green section. The passport also showed the circle of important people for the child or young person.
- In order to overcome barriers to accessing services, health visitors worked with families of ethnic minority groups to identify their needs. We heard an example of one family who had not socialised their children and consequently the children were behind developmentally. The health visitor made an appropriate safeguarding referral and the single assessment process was put in place. Services became involved with the family including the speech and language therapy team and nursery and the family were now doing well. The health visitor maintained close contact with the family throughout the whole process.

Access to the right care at the right time

- The school nursing team had introduced a new texting service for 11-16 year olds called 'ChatHealth'. A pocket-sized card with the text number had been circulated to children in secondary schools. School nurses could view the texts, respond quickly to requests for advice, and help on a number of issues including bullying, self-harm, smoking and mental health. Staff gave an example of how they had responded to requests for the morning after pill the same day.
- The Family Action Support Team (FAST) had been under a service review since December 2016 and senior managers had told them to put their waiting list on hold until further notice. Staff told us two weeks prior to our inspection visit they had been told to reopen the waiting list and had accepted 34 new referrals onto the list.
- Data submitted by the service prior to inspection showed there were 32 referrals still waiting for assessment. The mean number of days from referral to initial assessment was 126 and from initial assessment to treatment 32 days. There was no waiting time targets for this service. Senior managers told us that the waiting list contained a large proportion of inappropriate referrals, which contributed to delays and there were plans in place to address this in future.
- The school nursing team had set up a duty phone line, which was staffed Monday to Friday from 12pm to 5pm. Calls and emails were responded to immediately within this period and escalated to the appropriate school nurse if urgent.
- Children received vaccinations as part of the routine immunisation programme rolled out in schools. Children educated at home were invited by letter to attend immunisation clinics.
- Student health visitors as well as qualified health visitors had the opportunity to undertake training to become Community Practitioner Nurse Prescribers. There were 34 non-medical prescribers in the health visiting service. This gave patients quicker access to some medicines.

Learning from complaints and concerns

- Children's Health Provision (CHP) received one formal complaint in the 12 month period prior to 9 December 2016. This complaint was in relation to the health visiting service.
- School nurses and health visitors told us they did not receive many formal complaints and they tried to resolve concerns and complaints before they escalated. Health visitors reported that most issues were from parents and carers requesting to change their health visitor and these were resolved locally by a team leader through early intervention.
- Formal complaints were investigated by the team leaders and responded to by the service manager. We saw the written response to one complaint relating to the health visiting service. The complaint was responded to in a timely manner and gave a detailed account of how it had been investigated and resolved. The letter included an apology and an explanation of how to progress to the next stage of the complaints procedure if they were not satisfied with the response.
- Information on how to make a complaint or share a concern was available on the North East Lincolnshire Council website. Compliments, complaints and concerns about the service were recorded on a log and shared with staff at monthly team meetings.

Community health services for children, young people and families

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

Leadership of this service

- The service was led by the Head of Children's Health Provision with oversight from the Director of Prevention and Early Help. There was a service manager for school nursing and for health visiting, with two school nurse team leaders and five health visitor team leaders. The Family Action Support Team had a team leader who reported directly to the head of service. The school nurse service manager was on maternity leave at the time of our inspection and their role was being covered by the health visiting service manager.
- Staff told us there were not aware of succession planning to arrange maternity cover for the school nurse service manager. The health visitor service manager was now providing cover but staff were unsure of the level of support they were receiving.
- We reviewed information during the inspection and could not find evidence the service had carried out necessary employment checks on directors of the service.
- The Family Action Support Team (FAST) team leader met regularly with the head of service and attended the practitioner reference group. Information from these meetings was cascaded to staff in the team. Staff said their team leader was doing a good job.
- Health visitors spoke positively about local leadership and their service manager. They told us team leaders were visible and actively involved in the daily operation. They said the service manager had good oversight, was approachable and accessible.
- School nurses spoke highly of their service manager who was on maternity leave at the time of our visit. Staff told us their service manager was forward thinking, passionate about their services and was an inspirational leader. However, some staff told us they did not feel confident about the leadership above this level.
- Health visiting staff felt they had good leadership from their immediate managers, however they did not always feel supported by the head of service. They thought the head of service did not have a good understanding of the services they provided. Staff told us they had invited the head of service to a meeting to share their concerns, however, the head of service had cancelled their attendance due to other service priorities and rearranged to visit the team at a later date.

Service vision and strategy

- The overarching local authority strategy was focused on developing a more integrated health and social care provision. The Children's Health Provision (CHP) strategy across the 0-19 age range, aimed to create stronger communities and the strategic framework was composed of five principles: health and well-being; economic; prevention and early help; finance and safeguarding.
- Senior managers were in the process of reviewing the current model of care for health visitors, school nursing and the Family Action Support Team (FAST). Managers stressed this was not a restructure but a remodelling of services, building upon the success of what was currently working well. Future proposals included plans to incorporate speech and language therapy, and the child and adolescent mental health service (CAMHS).
- The primary vision and aim was to keep improving outcomes for children and young people so they thrived and were kept safe. This involved reviewing the provision of care delivered by health visitors for babies and children up to three years. Smaller teams would be created in some cases to work closely with vulnerable families with a focus on prevention and early help.
- Senior managers told us the six Cs of care, compassion, competence, communication, courage and commitment, were fundamental to their values.
- Staff we spoke with were aware of the six Cs and the vision and values of North East Lincolnshire Council Children's Health Provision.

Governance, risk management and quality measurement

- Team leaders told us risk assessments were completed for all activities at each base and were stored on a shared drive. Any risks, which could not be reasonably managed, were escalated to the head of service for discussion at the Senior Management Team meeting (SMT).
- The clinical compliance and quality lead told us that risks were analysed in detail and the broader impact was considered. A scoring system was used to grade

risks. The decision to escalate a risk onto the risk register was made by the SMT and shared with the clinical commissioning groups. Risks were regularly monitored and reviewed.

- SMT meetings were held monthly. We reviewed the minutes of these meetings and saw complaints, compliments, incidents and risks were standard items for discussion on the agenda. New guidance/protocols for CHP were also reviewed and ratified at this meeting.
- Issues identified at the SMT meeting were escalated to the Clinical Governance Provider Group, which in turn fed into the Assurance Board.
- There were two risks identified on the risk register. A lack of midwifery notifications to health visitors resulting in antenatal contacts not being undertaken and pressure to deliver the Healthy Child Programme (HCP) as a result of a reduction in the health visitor workforce. This did not fully align with risks we had identified on inspection for example lack of oversight of mandatory training and staff appraisals.
- We had concerns that the leadership team did not have full oversight of risk and the quality management of the service. They had not identified all risks and did not have concerns about low incident reporting in the services they provided.
- Waiting lists for the Family Action Support Team (FAST) were not being effectively managed and were not identified as a risk on the risk register.
- Staff had alerted senior managers to the risk that they would not be able to deliver the full Healthy Child Programme (HCP) and suggested retaining nursery nurses in the service. However, this had not happened. A health visiting team leader told us a meeting had taken place to find a solution to deliver the full HCP. The team leader felt that additional time would be available if health visitors did not attend all case conferences unless a specific issue relating to health needed to be discussed. They felt it was not always the best use of their time to attend a four hour case conference if they had nothing to contribute.
- Prior to approval of the voluntary redundancies, the relevant staff from the Children's Health Provision leadership team reviewed impact on caseloads and ensured service delivery was safe and there would be no direct risk to children and families. The health visitor service manager said the risk to not delivering the full contacts for the HCP had been mitigated by introducing targeted contacts. However, staff were concerned about the risk to children not receiving all visits. They were worried safeguarding concerns may go unnoticed and would therefore not be addressed.
- Health visitors and school nurses attended monthly forum meetings. There was a standard agenda, which included operational issues, service development and guest speakers. Senior managers had recently attended the forums to update and consult with staff on the service re-design.
- Staff also attended local team meetings. Some staff said these could be irregular and they did not receive much information from managers above their service manager.
- The health visitor service manager told us she regularly received patient outcome data from the business support team. However, team leaders and health visitors did not appear to be aware of this or have sight of their performance. Most health visitors said they worked towards delivering 100% on all contacts.

Culture within this service

- Managers acknowledged staff were feeling vulnerable during the period of service redesign and change. They tried to give staff the opportunity to talk about their concerns by attending staff meetings/forums and said they had an open door policy should staff wish to speak with them.
- Staff morale was low in the Family Action Support Team (FAST). Staff told us they felt undervalued by the organisation and not invested in; however positive feedback from parents and other professionals made them feel appreciated. They felt passionate about the service they provided.
- Although there was some anxiety about the outcome of the consultation on the new model of service delivery, morale in the school nursing team was good. Staff told us they got on well with each other and there was a good team spirit.
- The health visitor service manager said morale tended to go up and down across the service, in peaks and troughs. They tried to ensure staff received a consistent message in relation to the proposed changes and kept them up to date with current information.
- The majority of health visitors we spoke with told us they felt valued and respected by their immediate line

manager but less so by senior managers. Staff felt the wider organisation did not understand the health services they provided and this made them feel de-valued.

- We found measures were in place to protect staff who were lone working. Staff told us they followed lone worker guidelines and made local arrangements to ensure they were kept safe. Staff went in pairs if they visited a family where there was a potential risk to their safety and recorded their visits in the ledger on the electronic system. Team leaders told us they had access to car details and emergency contact details. Managers were very clear on the importance of keeping staff safe when lone working.
- Staff in the Family Action Support Team (FAST) told us about training they had undertaken in restorative practice. Staff told us the principles of restorative practice were 'doing with' not 'doing to' and creating a culture of effective support and effective challenge. This training was being rolled out across the organisation. Restorative practice was a key part in the vision to create stronger communities.
- Staff described the culture as open and said they felt safe to own up if they made a mistake. Staff did not feel there was a blame culture.
- Staff sickness levels for Children's Health Provision (CHP) were 7.7% at the time of our visit. There was a policy for managing sickness absence and managers told us there was a process to manage sickness, which included triggers relating to the number and duration of staff absences. Staff told us sickness absence levels were high and this needed to be better managed.
- A member of staff told us they received very good support from their team leader during and following a period of long term sickness absence. The team leader had maintained regular contact and organised additional support to facilitate her return to work.
- Although staff felt unsure about the service reconfiguration, we found they were passionate about and proud of the services they offered to children, young people and families. They told us that they put the patients at the centre of what they do.

Public engagement

- Senior managers told us they had held public engagement events to share information and gather feedback about the proposals to changes in service provision.
- The school nursing service had involved young people in the development of promotional material used to advertise the new text service in schools. They had used this feedback in the design of promotional material for the new service to ensure it was appealing to young people.
- The health visiting service did not have any formal mechanisms in place to gather feedback from families who used the service. Staff we spoke with acknowledged they did not distribute patient surveys or comments cards to capture feedback and would like to introduce this into the service. The service manager said they were in the process of adapting the Friends and Family test and planned to roll it out across the service.

Staff engagement

- Senior managers had held several engagement meetings with staff to share proposals and plans for the remodelling of services. Staff we spoke with told us this provided opportunities for them to share their thoughts and opinions about the proposals.
- A staff consultation was carried out in June 2016. We saw the results of the survey, which gave details of the key findings and an action plan to address areas of concern.
- We saw evidence that health visitors had been given the opportunity to influence the service redesign using their local knowledge and experience. This was encouraged by senior managers. Health visitors we spoke with said when issues were discussed, they felt listened to but also felt as though managers had already made their mind up as to what the future of the health visiting service looked like.
- Staff told us a senior director had accompanied a health visitor team leader on a home visit to a family with complex needs who lived in a highly deprived area. The team leader told us their purpose was to see how the service operated on the front line and gain a better understanding of the work they did.
- An annual 'leading lights' award ceremony was held across all teams to recognise staff for exceptional work.
- Staff received a two weekly newsletter to update them on current news and themes.

Innovation, improvement and sustainability

- The Family Action Support Team (FAST) offered a parallel programme working together with parents and children. This was an innovative approach to identify

social skills deficit and work with both children and parents to build their knowledge and resilience. The team had received national and local awards for innovative practice.

- The school nursing service had introduced a new way for young people to get advice and support about health related issues. 'ChatHealth' was a school nurse text messaging service for young people aged 11-16 years. The service enabled students to speak with a nurse by instant messages on smartphones after logging-in with a username and password. This service improved access to healthcare for young people, using a method of communication with which they were comfortable.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure there is an effective system for recording mandatory and statutory training in order to provide assurance to managers that staff have completed the required training.
- Ensure regular robust infection prevention and control audits are carried out within the service.
- Ensure that all staff receive a yearly performance review and development appraisal and have a system for monitoring this.
- Ensure there is an effective system for identification, oversight and management of risks to the service.
- Ensure they have carried out the necessary employment checks on directors of the service.

Action the provider SHOULD take to improve

- Review staffing capacity and skill mix to ensure they are able to deliver the full Healthy Child Programme (HCP) to all children and families.
- Ensure waiting lists are managed effectively to allow timely access to services especially in the FAST service.
- Ensure all staff receive training on incident reporting.
- Ensure all staff receive adult safeguarding training.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes were not always operated effectively to ensure improvement and good governance of services. The provider must: 1. Ensure there is an effective system for recording mandatory and statutory training in order to provide assurance to managers that staff have completed the required training. 2. Ensure regular robust infection prevention and control audits are carried out within the service. 3. Ensure that all staff receive a yearly performance review and development appraisal and have a system for monitoring this. 4. Ensure there is an effective system for identification, oversight and management of risks to the service.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: Recruitment procedures were not established and operated effectively to ensure that persons employed met the required conditions. The provider must: 1. Ensure they have carried out the necessary employment checks on directors of the service.