Solutions 4 Health Limited

Solutions 4 Health - Barnet

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We had not previously inspected this location. We rated the service as inadequate for safe, requires improvement for effective, responsive and well-led and good for caring. This was because:

- The service did not have robust safeguarding systems and processes in place in order to ensure children, young people and their families were appropriately assessed, reviewed and identified risks were managed. Children transferring into the service were not always seen within the timeframe set out in the provider's own policy and the care of families identified as vulnerable or high risk was sometimes poorly managed. Staff who held a clinical caseload did not receive regular safeguarding supervision to discuss and reflect on their clinical practice. The concerns identified increased the risk of children and their families coming to avoidable harm.
- The service did not have robust governance and assurance systems in place to monitor the quality and safety of the service and respond quickly to areas that required improvement. Although senior leaders knew most areas of the service that needed to improve, they were not clearly sighted on the extent to which children, young people and their families were put at risk due to inconsistencies in clinical practice and ineffective systems in place. The provider did not have effective arrangements to ensure that all notifications were submitted to external bodies as required.
- The service did not offer all mandated checks required by the Healthy Child Programme (HCP) to families on the universal pathway. The service was experiencing demand and capacity issues that meant they could not deliver every aspect of the HCP to universal families including the mandated six to eight-week check. The six to eight-week check is a vital part of the HCP and by not seeing new parents and carers there was a risk that their full needs would not be identified, including any mental health needs.
- Staff did not always complete records in sufficient detail. Some patient records lacked important information and there was an inconsistent approach to the recording of clinical decision making. The lack of clear record keeping increased the risk of important information not being shared and potentially missed.
- The service did not ensure staff received regular clinical supervision. The provider did not collect data relating to the completion of clinical supervision. Some staff we spoke with told us that they had not received clinical supervision since the provider took over the service in April 2022. The lack of consistent clinical supervision meant that staff did not have an opportunity to assess and reflect on their performance and seek support where required.

However:

- The service recognised that parts of the service needed to improve and had employed external consultants to support the service with the changes. The provider had employed external consultants to work with staff to improve morale and identify new ways of working. The health visiting service was being reviewed by an external specialist. The school nursing service was implementing a new model of care called The Lancaster Model.
- The service was committed to improvement and ensuring the service met people's needs. The service had purchased a small bus that was being adapted so that the health visiting service could be delivered to children and families out in the community. The service envisioned the bus to be placed at shopping centres and popular venues across Barnet as a way of engaging more families.
- The provider was recruiting more staff into essential roles. The service had employed a perinatal specialist health visitor and a specialist lead for the maternal early childhood sustained home-visiting programme also known as MESCH. The service had also employed an auditor who would be responsible to enhance the services quality assurance processes as well as being the Freedom to Speak Up Guardian.
- Staff across the service were dedicated to improving the health and wellbeing of children, young people and their families. During the inspection, we observed caring and positive interactions between staff and families.

Summary of findings

- The service had a clear vision of where it wanted to be. Staff had attended a team vision planning workshop. The workshop was an opportunity for the health visiting team to set out their future ways of working and build their vision together.

As a result of the concerns we identified we issued the provider with a Warning Notice under Section 29 of the Health and Social Care Act 2008. The provider had failed to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We require the provider to make the necessary improvements and be compliant with the regulation by 13 January 2023. You can see full details of the regulations not being met at the end of this report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for children, young people and families	Requires Improvement 	We rated it as requires improvement. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Solutions 4 Health - Barnet

The Solutions 4 Health - Barnet service provides an integrated health visiting and school nursing services that supports children and young people aged zero to 19 and their families. The service covers the London Borough of Barnet. The health visiting team is comprised of three locality teams; South, East Central and West. The school nursing team are not split into localities.

The registered provider of the service is Solutions 4 Health. The delivery model for the health visiting team is based on the nationally mandated Healthy Child Programme (HCP). The health visiting team delivers the part of the HCP that is for children aged zero to five. The programme requires children and families to receive five mandatory checks: an antenatal contact at 28-weeks pregnancy, a new birth visits within 14 days of birth, six to eight-week reviews, one-year development reviews, and two to two-and-a-half-year development reviews. The school nursing team delivers the part of the HCP that is for children and young people aged five to 19. The Healthy Weight Nursing team are part of the wider school nursing team and deliver the mandated National Childhood Measurement Programme. The service also has an oral health team and an infant feeding support team. The service supports children and families in their homes, children's centres, clinics, health centres, GP premises and schools. We visited Newstead Children's Centre as part of our inspection.

The regulated activities attached to this service are diagnostic and screening procedures, family planning and treatment of disease, disorder or injury. There is a registered manager in post. There had been no previous inspections completed at this location. Therefore, we did not need to follow up on any outstanding compliance or enforcement actions.

All families we spoke to during the inspection were positive and satisfied with the service they had received. Families said that staff were compassionate, caring and supportive. We spoke with 11 separate parents and carers.

Following the inspection, we received three separate complaints from families who told us that they had not received a good service. The families said that they were unable to contact the service and they had not received the required checks for their child.

How we carried out this inspection

Our inspection team comprised of one CQC inspection manager, two CQC inspectors, two specialist advisors with clinical backgrounds in safeguarding and health visiting and one expert by experience.

During the inspection we:

- spoke with 11 families who had used the service
- spoke with 15 members of staff including locality managers, team leads, health visitors, school nurses and nursery nurses
- spoke with four senior leaders of the service including the registered manager
- reviewed electronic records detailing the care and treatment of nine patients
- reviewed 13 safeguarding supervision records
- attended one child development clinic and visited one children's centre
- looked at a range of policies, procedures and documents related to the service

Summary of this inspection

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

Outstanding practice

We did not identify areas of outstanding practice.

Areas for improvement

Action the service MUST take to improve:

- The provider must ensure that it has robust governance and assurance systems in place to oversee and monitor the quality and safety of care and respond quickly to areas requiring improvement. Regulation 17 (1)(2)
- The provider must ensure that safeguarding systems and policies in place are robust and staff who require safeguarding supervision receive this every three months with a qualified safeguarding supervisor. Regulation 13 (1)(2)(3)
- The service must ensure that they continue work to improve performance in completing checks for the mandated milestones outlined in the Healthy Child Programme. Regulation 12 (1)(2)(a)(b)
- The provider must ensure that clinical records are up to date with important information and includes rationale for clinical decision making. Regulation 12 (1)(2)(a)(b)
- The provider must ensure that clinical staff receive regular clinical supervision and all staff receive the required mandatory training. Regulation 18 (2)(a)
- The provider must ensure that the Care Quality Commission is notified of all incidents requiring notification, without delay. Regulation 18(1)(2)(e) (Registration) Regulations 2009

Action the service SHOULD take to improve:

- The service should continue to ensure that staff morale is improved across the service.
- The service should ensure that staff uphold infection control principles and record when they clean clinical equipment and children's toys.
- The service should ensure that they strengthen and improve the ways in which families are able to give informal feedback and compliments about their experience.
- The service should ensure that communication with local midwifery services is improved.
- The service should continue to ensure that the service's specialist education needs and disability (SEND) offer is developed and implemented. This includes ensuring staff access additional training on Autism and SEND.
- The service should ensure that parents and carers are able to access information leaflets in a range of languages.

Our findings

Overview of ratings

Our ratings for this location are:

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

Community health services for children, young people and families

Requires Improvement

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

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

Inadequate

Mandatory training

The service provided mandatory training in key skills but not all staff had completed it.

Whilst the service provided mandatory training in key skills to all staff, at the time of our inspection the mandatory training compliance rate was 47%. This was below the target rate of 85%. The lowest level of compliance was for infection prevention and control training (42%) and mental health awareness (34%). Staff told us that the demand on the service and the lack of staffing impacted on them being able to complete required training. The provider was sighted on the low compliance rate and was working with HR to determine which mandatory training courses were the highest priority. The provider had plans in place to offer staff protected time to complete any outstanding mandatory training sessions. The low compliance rate was recorded on the service's risk register with appropriate controls in place.

Safeguarding

The service did not have effective safeguarding systems and processes in place to ensure children and their families were appropriately assessed, reviewed and identified risks were managed.

In five out of 13 safeguarding records reviewed, the service had failed to ensure that the families had received the right level of care and support when they transferred in or out of the service. In two individual records, we identified that that the children had moved into the London Borough of Barnet from abroad and had not been seen by a health professional within the timeframe set out in the provider's own policy. For example, one family had transferred into the service in May 2022 and at the time of our inspection had not been allocated to a health visitor and there was no evidence in the record that demonstrated that the child had been risk assessed. The other child had transferred into the service in September 2022 and was the subject of a child protection plan. They had not been allocated to health visitor until 3 November 2022. At the time of our inspection, the child and family had not been visited at home by a health visitor and an alert indicating the child's vulnerability had not been put on to the electronic record. The provider's standard operating procedure for the Healthy Child Programme stated that for any child transferring into the service were to be allocated to a health visitor within one to three working days. We found that the service had not adhered to their own policy. The unsafe safeguarding systems and processes put children at risk of improper abuse and treatment.

Staff had not all completed safeguarding training. At the time of our inspection, the mandatory training compliance rate for safeguarding adults and children level three training across the service was 48.9%. The target was 85%. Whilst the provider had plans in place to improve the completion rate, the low level of compliance meant that the provider could not be fully assured that staff were able to identify and respond to the needs of vulnerable children and their families. Following the inspection, the provider put a plan in place to ensure that the service met the training compliance target by the end of January 2023.

Safeguarding supervision was not consistently taking place. We identified in three out of 13 safeguarding records that safeguarding supervision had not taken place with the allocated health visitor or health professional since the provider took over the service on the 1 April 2022, despite the individual cases being complex. There was no record of safeguarding supervision in the care records. The provider told us that 81% of health visiting staff and 55% of school nurses had received one episode of safeguarding supervision since April 2022. However, this was not in accordance with the provider's supervision policy. The provider's own supervision policy stated that 'all staff working with children and young people will have regular three monthly 1:1 safeguarding'. The lack of consistent safeguarding supervision in line with the provider's own policies and procedures meant that health visitors and school nurses overseeing complex child and family cases have not had the opportunity to evaluate, reflect and plan the right care with a trained safeguarding supervisor. This increases the risk of staff missing the opportunity to recognise any gaps in their skills and knowledge that are needed to effectively safeguard children and their families.

Information contained in the provider's safeguarding vulnerable adults and children policies was not always correct and comprehensive. For example, we reviewed a document that was referred to as a modern-day slavery policy. However, the information recorded was a statement and did not guide staff in how to respond to a concern. The service did not have a specific policy in place that guided staff in how to respond to bruising injuries in non-independent mobile babies. A member of staff told us that in June 2022 they had a concern about bruising in a child they had seen. The member of staff was unsure how to manage the concern. In addition, the safeguarding children's policy referred to legislation relating to Liberty Protection Safeguards that do not currently exist in law. We reported this to the provider to address.

Staff had access to safeguarding advisors who were available during core working hours to respond to frontline colleagues needing advice and support. A safeguarding advisor from the 0-19 team was located in the local authority multi-agency safeguarding hub, which supported effective safeguarding partnership working. Staff told us that the advisor notified the team of any notifications received from local hospitals. The service cascaded safeguarding 'at a glance' newsletter. The newsletter informed staff about key legislation, safeguarding practices and learning from national safeguarding reviews.

Cleanliness, infection control and hygiene

The service controlled infection risk well and risk assessed the facilities they used at local children's centres. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean and used personal protective equipment when required.

The service had an infection control policy in place that guided staff in how to ensure infection control principles were upheld. We inspected the clinical areas that the staff used at Newstead Children's Centre. Staff ensured that they allowed enough time between each family so that they could thoroughly clean the clinical areas and toys. Staff told us

that although they did not record when they cleaned individual toys, the toys were cleaned after every use and were only used by Solutions 4 Health staff. We observed this in practice. The lack of recording when equipment had been cleaned meant that staff could not be assured that equipment was clean before use. This increased the risk of infections spreading.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Staff were trained to use equipment. The service was in the process of ensuring all staff had a personal panic alarm that they could wear whilst working alone in the community. The provider planned to issue staff with a personal panic alarm by the end of November 2022. In the interim, the service had put in place a 'buddy' system which meant staff were required to inform their colleague of their whereabouts at any given time. The service had a lone working policy in place to guide staff when working alone.

Assessing and responding to patient risk

The service was unable to offer all aspects of the Healthy Child Programme. Managers had prioritised new birth visits and visits to families with increased risks, but some families with increased risks had not received an in person new birth visit. Staff did not always complete and update records in sufficient detail. The service was not effectively managing the allocation of families.

Since the provider took over the 0-19 service in April 2022 the service had been unable to offer all aspects of the Healthy Child Programme (HCP) to families on the universal pathway. This is largely due to insufficient staffing to meet the service demand. The service focused their resources on ensuring families requiring enhanced or targeted support were seen. The HCP is used by health visitors to assess and monitor the welfare and key stages of development in children, young people and families. This is a national mandated public health programme, requiring staff to screen, immunise, and review the development of children at specific points in their lives. The programme allows staff to identify risk of harm, disorder, ill health, or need for additional support.

Staff completed many new birth visits (NBV), including some to families with increased risks, virtually. This was not in accordance with the providers own policy, which stated that a health visitor is required to carry out an NBV at the child's home in person. For example, in September 2022, the HCP performance data showed that 37.5% of families received a virtual NBV. Staff were not consistent in their approach to virtual NBVs putting children at risk of harm. For example, a health visitor had carried out a virtual NBV despite the child requiring the highest level of intervention due to being at risk of abuse. This meant that the health visitor was unable to fully assess the child at risk. Senior managers were not sighted on the high numbers of virtual NBVs being delivered. We escalated this to the provider to address. Following our inspection, the provider told us that they would ensure staff would be appropriately trained to deliver virtual NBVs using the guidance that had already been created for the new virtual wards model that was launching in December 2022.

The service had not delivered the mandated six to eight-week HCP check to children on a universal pathway. In October 2022, the service identified that 368 families required a check, however, they were unable to offer them an appointment due to a lack of staffing. At the time of the inspection, the provider told us that the venues had been identified for the clinics and equipment was being dispatched. The provider planned to open the clinics by the end of November 2022. The six to eight-week check is a vital part of the HCP and by not seeing new parents and carers there was a risk that their full needs would not be identified, including any mental health needs.

Community health services for children, young people and families

Requires Improvement

Staff did not always complete patient records in sufficient detail. Patient records did not always demonstrate how risk was assessed and managed in accordance with the provider's own policy. We reviewed 22 patient records in total, 13 of which were safeguarding records. Of the nine remaining records, five lacked important information. For example, we identified that a child's record had not been updated between August 2022 and November 2022, despite the child being the subject of a child protection plan. The record did not include an alert to highlight to staff that the child was at risk of abuse. In another record, we found that the health visitor had not recorded their clinical decision making. They recorded 'no abnormalities detected' in relation to the child's physical health without documenting the assessment that was made. The lack of clear record keeping increased the risk of important information not being shared and potentially missed.

The service was not effectively managing the high numbers of families awaiting allocation. At the time of our inspection, the general allocations waiting list had 154 families awaiting allocation and the transfers in waiting list for children over one years old had 250 families awaiting allocation. Staff told us that team leads reviewed the waiting lists on a regular basis and vulnerable families were prioritised. However, during our inspection we identified two separate children on the transfers in waiting list that had not been allocated to a health visitor despite being transferred into the service (in May and September 2022) and were deemed as high risk. The waiting lists were unorganised and included families that required discharging from the service. The ineffective allocation system increased the risk of children coming to harm.

Staffing

The service had a high vacancy rate. Managers were implementing a new skill mix model and recruitment was taking place. Team leaders assessed the size of their team caseloads regularly and, where possible, helped staff to manage the size of their caseloads.

Whilst the service was experiencing a high health visiting vacancy rate, the service had staff with the right qualifications, skills, training and experience to keep children, young people and their families safe and to provide the right care and treatment. The teams with the highest vacancy rates were health visiting and school nursing. The health visiting team had a vacancy rate of 24.5% and school nursing had a vacancy rate of 34%. The provider was sighted on the staffing issues and had put controls in place to manage the gaps such as new recruitment adverts and incentives to attract new applicants and employing agency staff. The provider had also implemented a skill mix model which means a combination of clinical and non-clinical staff with different skills in order to deliver the required health checks. The service was in the early stages of recruiting more school nurses, community nursery nurses, specialist health visitors and community nurses.

The impact of the staffing issues meant that teams had to prioritise children, young people and families that were at risk and vulnerable. The provider had also agreed with commissioners that they would not be able to deliver aspects of the Healthy Child Programme (HCP) for families on the universal pathway such as the antenatal contact with expectant mothers at 28 weeks pregnant and the six to eight-week mandated check.

Team leaders assessed the size of their team caseloads regularly and, where possible, helped staff to manage the size of their caseloads. The service used a 'corporate caseload' model for the families on a universal caseload. Six staff we spoke with told us that their workload was unmanageable, and they were concerned they were not able to support vulnerable families.

Records

Community health services for children, young people and families

Requires Improvement

Records were stored securely and were easily available to all staff providing care, but they varied in the level of detail recorded.

Whilst records were stored securely and were easily available to all staff providing care, records were not always comprehensive and up to date. Staffing shortages meant that staff had increased workloads and were not always able to record their work as soon as possible after an appointment.

Medicines

The service worked with community GPs and acute hospitals to ensure medicines were managed safely.

The Newstead Children's Centre we inspected did not stock medicines. Clinical staff told us that they did not manage medicines as part of their role. Health visitors only provided vitamins to families as part of the Healthy Start scheme. Families and carers, we spoke with told us that their health visitor or school nurse gave advice about medicines, but their GP was required to prescribe medicines to them.

Incidents

Safety incidents were reported and investigated appropriately, but some learning from incidents had not been implemented robustly.

The service had been involved in a rapid review following an unexpected child death in April 2022. The investigation identified that it required a robust transfer in and out pathway. Records showed that the learning from the incident was shared during a team meeting, but at the time of the inspection, this had not been fully embedded into everyday practice. For example, we identified two separate families that had transferred into the service and there had been a significant delay in them being allocated to a health visitor and assessed in accordance with the providers own policy. The delays in children and families receiving the right level of care and support put them at risk of harm.

The provider had received two separate whistleblowing's from members of staff as well as a complaint since taking over the 0-19 service in April 2022. Staff had raised concerns about the leadership of the service, unsafe clinical practice, unmanageable workloads and children, young people and their families being at risk of harm. The provider acted promptly and investigated the concerns. As a result of the investigation, the provider made changes to the senior leadership team and all staff were offered a one to one support meeting with the registered manager. The provider employed two external consultants to review and support the health visiting and school nursing service. Staff were supported by a health psychologist who had been employed to support the service transition.

Staff understood the term duty of candour. Providers of healthcare services must be open and honest with patients and other 'relevant persons' (people acting lawfully on behalf of patients) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were able to provide examples of when they would offer support and apologise.

Community health services for children, young people and families

Requires Improvement

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

Requires Improvement

Evidence-based care and treatment

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

Health visitors and school nurses delivered most aspects of the national Healthy Child Programme (HCP) but was unable to offer all aspects to families on the universal pathway. This was largely due to the high demand on the service and not enough staff. The service focused their resource on families identified as vulnerable or requiring enhanced support. Health visitors and community nursery nurses used the 'ages and stages questionnaire' (ASQ), which is an evidence-based assessment tool that encourages parents as experts to provide information about the development of their child across five developmental areas. School nurses followed the national child measurement programme in primary schools. In the academic year of 2021-2022 the service had completed the measurement programme for 98% of eligible pupils.

The service had implemented new initiatives to ensure they reached as many children, young people and families as possible. The service used the maternal early childhood sustained home visiting (MECSH) programme. MECSH is a structured programme for sustained nurse home visiting for targeted families that aims to improve maternal and child health and developmental outcomes. The service had 25 families on the MESCH caseload. The school nursing service was implementing The Lancaster Model in January 2023. The model is an evidence-based online questionnaire designed to identify early health and wellbeing needs, allowing the team to respond quickly and provide support. The model is recommended by the Department of Health and Social Care.

Patient outcomes

The service had begun to monitor the effectiveness of care and treatment and was trying to make improvements from the findings to achieve better outcomes for children and young people.

The service was in the early stages of monitoring the effectiveness of care and treatment. The provider had a service development plan and strategy in place that included plans to work towards the UNICEF Baby Friendly Initiative, which aims to support breastfeeding and parent infant relationships. The service recognised that they were required to improve their recording and monitoring of breastfeeding data. The service had a new infant feeding team and a specialist infant feeding health visitor in post. The provider planned to improve the collection of information by the end of December 2022.

The service had arrangements in place to monitor the health and treatment outcomes of children, young people and their families. The leaders of the service used a dashboard to monitor the team's performance and maintain oversight on the delivery of the mandated Healthy Child Programme (HCP). This included antenatal contact, new birth visits (NBVs), six to eight-week reviews, one year and two-year developmental reviews. At the time of our inspection, the service was only able to offer antenatal contact to targeted families and not to families on the universal pathway. Pregnant women on the universal pathway were monitored via the local midwifery service. This was due to staffing issues. Performance data from September to November 2022, demonstrated that the service had achieved over the target of 90% for NBVs each month. Due to demand and capacity issues, the service had agreed with commissioners to

increase the days in which staff were required to complete the visit. The service had not been able to consistently offer developmental reviews to all children on the universal pathway aged 12 months and 2 to 2 and a half years of age. At the time of inspection, the service had recruited more staff and had begun to send out letters to families that included a developmental assessment questionnaire called the ASQ and an invite to a health review appointment to discuss the questionnaire outcome.

Competent staff

The service ensured that staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families, but staff did not always receive regular clinical and safeguarding supervision in accordance with the provider's own policy.

At the time of our inspection, we requested clinical supervision performance data from the provider. The provider was unable to provide performance data relating to clinical supervision and recognised that the recording of clinical supervision required improvement. We spoke with 16 team members from across the service and seven of them told us that they had not received one-to-one clinical supervision since the provider took over the service. One member of staff told us that they had received one session in eight months. Changes in the leadership of the service impacted on the frequency of clinical supervision. The provider recognised this and planned to formalise and embed the clinical supervision process into teams. The lack of consistent clinical supervision meant that staff did not have an opportunity to meet with their line manager to assess their performance and wellbeing and seek support where required.

The service had not been in operation for a full year; therefore, no staff appraisals had yet taken place.

The service required non-clinical staff to complete competency-based assessments before they were able to work independently. At the time of our inspection, one community nursery nurse was in the process of being signed off as competent. The provider showed us a copy of a competency assessment that is used in practice. Staff are required to attend study days and complete a competency framework document.

The provider had recruited specialist roles and was in the process of recruiting into additional posts. The service had employed a perinatal specialist health visitor and a specialist MESCH lead. The service was advertising for a range of specialist roles including a vulnerable families specialist health visitor post and a specialist educational needs and disabilities specialist health visitor.

Multidisciplinary working

All healthcare professionals responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

The teams held regular team meetings and planned to introduce a monthly 0-19 forum from December 2022. The meeting would be an opportunity to provide staff training, share learning from reviews and invite stakeholders to share information about their service. Service leads had planned for the Early Help team to attend the December 2022 meeting.

Community health services for children, young people and families

Requires Improvement

The service was in the early stages of building links with local stakeholders and improving communication with system partners. The service did not have enough health visitors to allocate one to each local GP practice, therefore the service planned to share team leader contact details with GPs so that they can access direct support. Staff told us that communication with the local midwifery service required improvement. On one occasion, a health visitor had contacted the family to organise an ante-natal visit, but the baby had already been born.

Health promotion

Staff had not always been able to give children, young people and their families practical support and advice to lead healthier lives due to the service not being able to offer all mandated HCP contacts.

The service had begun to make improvements. It had recruited more community nursery nurses, so that more developmental reviews could take place, and was restarting the offer of the six to eight-week check. The mandated contacts are a vital opportunity for health promotion. The service also had a dedicated infant feeding team that families could directly contact for support. We observed a clinic at a children's centre and found that the staff member discussed key elements of health promotion such as injury prevention, immunisations and dental health with the parent. The staff member completed the personal child health record (red book). This is in accordance with the HCP. The service had a small oral health team in place that was responsible to teach parent, families and schools how to maintain good oral health hygiene. The school nursing team were working with local schools to plan drop-in sessions and parent and carer coffee mornings. At the time of inspection, staff told us that this was an area that could be improved. The service planned to re-introduce drop-in session when the new model of care was implemented.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment.

Staff knew how to support parent or carers when making decisions for their baby or child. They recorded that they had gained consent from families in order to share information with other agencies. The overall compliance rate for mental capacity act training was 52%, this was below the provider's target of 80%. The provider was planning a training session for all staff at the 0-19 service before the end of February 2023.

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

Good

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed interactions between staff and families to be friendly and caring. At the time of our inspection, we spoke with 11 individual families and they told us that staff were kind and supportive. However, after the inspection the CQC received three separate complaints from families who told us that they had not received a good service. The families said that they were unable to contact the service and they had not received the required checks for their child.

Community health services for children, young people and families

Requires Improvement

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

During a home visit we attended, the health visitor understood and respected the families cultural and religious needs. We spoke with 11 families that had used the 0-19 service and they all reported a positive experience. Families told us that the health professional they spoke with provided advice when they needed it and made them feel comfortable.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their care and treatment.

Staff followed a family centred approach. One family told us that a school nurse supported the teachers at a school in how to manage their child with a diagnosis of epilepsy. The family described the nurse as being helpful and informative.

The service did not routinely gather general feedback about service-user experience. During the inspection, we asked the provider to share with us examples of feedback received since taking over the 0-19 service. The service had created feedback forms that were being sent out to families after their appointments. The provider told us that the service had recently learnt that general feedback including compliments were not formally recorded on the electronic system, therefore they were unable to share the information with us. The provider was sighted on the issue and had plans to address the gap in service-user feedback.

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

Requires Improvement

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Service leads met regularly with commissioners to discuss performance targets and improvements they needed to make. They also worked with others in the wider system and local organisations to provide updates about the service and to plan care moving forward. For example, service leads had attended the local primary care multi-disciplinary meeting to provide an update on the service and to answer questions from the group. Local GPs had raised concerns that parents and carers were unable to contact the service directly via telephone. As a result of the concerns raised, the service had put in place a new telephone system and had reviewed the overall communications process.

Staff met children, young people and their families at various locations in the community dependent on the needs of the child. Health visitors predominantly met children and their families at their homes or in children's centres. School nurses mostly carried out their work on school premises during term-time. The 0-19 service was open during core working hours Monday to Friday 9am until 5pm.

Community health services for children, young people and families

Requires Improvement

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. Information was not, however, always available in different languages.

The service had purchased a small bus that was being adapted so that health visitor clinics could be delivered to children and families in the community. The service planned to park the bus at shopping centres and popular venues across Barnet as a way of engaging more families. The bus would include some clinical equipment such as baby weighing scales. The service involved local schools in the design of the bus and ran a competition for them to enter. The best design was selected for the branding of the bus.

The provider had also created a mobile application called 'AskTeddi' that offered free advice and support to families and carers with children under the age of five. The application used artificial intelligence and could be used in conjunction with support from health visiting services. Solutions 4 Health – Barnet planned to embed the use of the digital application into clinical practice and encourage families to utilise it. The application provides advice relating to early years, breastfeeding and healthy eating. The application has been independently evaluated by two separate universities and the results demonstrated that the application useful and informative.

Although Barnet has a diverse population, the service did not always ensure that information leaflets and letters sent out to families were available in languages spoken by the children, young people, their families and local community. For example, the service had sent out an ages and stages questionnaire (ASQ) for families to complete prior to a development review. However, the letter and questionnaire were in English only, therefore the service could not be assured that parents and carers understood the questions being asked. A family we spoke with told us that they had not received any leaflets in their first language of Arabic, and they required someone else to translate them on their behalf.

The service had plans to develop their specialist education needs and disability (SEND) offer. The service's development plan set out a range of actions that will enable the service to monitor and fully support children with SEND. By the end of March 2023, the service planned to identify a SEND professional lead and to introduce the service to local partners such as the Barnet Special Education Needs and Disability Advice and Support service. The service recognised that all staff required additional training on Autism and SEND and they planned to address this by September 2023.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly.

The service was unable to offer all of the mandated contacts that are set out in the Healthy Child Programme. This was largely due to a lack of staffing and high demand on the service. The service focused their resources on vulnerable children and families. The registered manager, senior leaders and commissioners were aware of the gap in care and were working to address the problem. Following the inspection, the CQC received three separate complaints from families. They told us that they had been unable to contact the service when they needed support and their children had not received the required checks.

Community health services for children, young people and families

Requires Improvement

The service had a Single Point of Access (SPA) system in place to manage children moving between services. The service had an established administration team that was working with the wider 0-19 team to improve administration processes. The team had assigned roles to effectively manage the demand on the service. The service utilised the Child Health Information services, also known as the CHIS, to identify families that had moved into the area. The service had begun to send out text message reminders to families to encourage them to book in their next review.

Whilst the service had a procedure in place for managing children moving in and out of the area, we identified during the inspection that the procedure was not always followed. We identified three separate families that had moved in and out of the London Borough of Barnet and had not received the care set out in the provider's own policy. The lack of adherence to the provider's own policy increased the risk of children and their families being put at risk of preventable harm.

Learning from complaints and concerns

People were able to give formal feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

The service had a system in place to manage complaints received. Between April 2022 and November 2022, the service had received seven formal complaints. We reviewed two separate complaint investigations. One related to the whistleblowing concerns received and the other related to the unanswered calls coming into the service. The complaints were fully investigated, apologies given, and lessons learnt were identified. Managers investigated complaints and shared identified themes during team meetings.

Parents and carers, we spoke to understood how to complain and feedback to the service. The families told us that they were happy with their experience and did not need to complain. Service leads recognised that the service needed to improve how they gathered and monitored informal feedback from service-users. Around the time of our inspection, the service had begun sending out feedback surveys to families and carers after every contact.

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

Requires Improvement

Leadership

Whilst the leaders had the skills and abilities to run the service, they did not always manage the priorities and issues the service faced at the speed that was required.

During our inspection, we found that the leaders understood most areas of the service that required improvement. However, they were not fully aware of the extent to which children, young people and their families were put at risk due to inconsistencies in clinical practice and ineffective safeguarding systems and processes. For example, we identified that some health visitors were undertaking virtual new birth visits, and this was not in accordance with the provider's own policy. The leaders of the service were not aware that this was common practice and, as a result, were not monitoring the quality of the contacts being delivered. Prior to our inspection, there had been some instability in the leadership of the service due to staff changes. The service had appointed a new head of service and two new locality leads for the health visiting service.

Community health services for children, young people and families

Requires Improvement

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The service had created two operational models called 'as is' and 'to be'. The 'as is' model explored the current situation within the service and mapped out the areas that needed to be addressed in order to meet quality standards. The service described the 'to be' model as moving the service from 'good to great'. At the time of our unannounced inspection, the service had planned for a team vision planning workshop. The workshop was an opportunity for the health visiting team to set out their future ways of working and build their vision together.

Culture

Some members of staff in the health visiting teams did not feel supported, respected and valued. The service had put in places measures to improve the culture and support staff to raise concerns without fear. The service promoted equality and diversity in daily work.

The culture of the service was improving. Since the service transferred to Solutions 4 Health, some members of staff had raised concerns about the general safety and performance of the service as well as poor leadership. The provider responded promptly and investigated the allegations made. Various support mechanisms were put in place for staff to access including a one-to-one meeting with a counsellor and also a health psychologist.

During the inspection, most staff we spoke to from the health visiting team told us that they did not feel supported, respected and valued. We spoke to 11 members of staff and 8 of them told us they either felt overwhelmed, stressed and they did not always have time to engage in professional development. Staff from other teams told us that they did feel supported and felt confident to raise any issues with their line manager. Despite staff having different experiences, all 19 members of staff we spoke to from across the service told us that their priority and focus was to ensure they delivered a good service and promote health and wellbeing for children, young people and families across Barnet. The service had recruited a new member of staff who was going to take up the additional role of Freedom to Speak Up Guardian. The role was to commence from December 2022.

The service promoted equality and diversity in daily work. Staff we spoke with gave examples of when they had been sensitive to a family's cultural and religious needs. Sixty-two percent of staff had completed the mandatory equality and diversity training. The provider's target was for all staff to achieve 80%.

Governance

Whilst leaders had governance processes in place, these were in their infancy and did not always operate effectively. The service leaders had failed to ensure that the assurance systems in place were robust enough to monitor, identify and address risks that impacted on patient safety.

During the inspection, we identified the following concerns:

- Leaders had not identified that staff were not always adhering to the provider's own policy and ensuring families were seen within the agreed timeframe. We identified a number of families that were vulnerable or high risk and had not received the level of care required. Two separate families were waiting to be seen despite them transferring into the service from abroad. This put them at risk of preventable harm.
- Staff who held a clinical caseload did not always receive safeguarding supervision despite the individual cases being complex.
- The service did not have a policy and escalation pathway in place in the event that a child was identified with bruising. The provider's safeguarding policy did not refer to this.
- The service had a low compliance rate of 48.9% for safeguarding level three training.
- Service leads lacked oversight of the number of families receiving a virtual new birth visit. The provider had not recognised that this was common practice and was not in accordance with their own operational policy.

Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. During the new 0-19 forum the service leads planned to share more information about service performance to the wider team. Senior leaders met on a regular basis to discuss key performance indicators, incidents and complaints. Information relating to quality and performance was reported up to the senior leadership team who then reported to the provider's board. We reviewed a sample of the provider's quality and safety meeting minutes and board meeting minutes from April 2022 to November 2022. We found that service risks, challenges and performance were discussed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance and risk but did not always effectively mitigate the safety risks.

Whilst the senior leaders were sighted on most of the areas we had identified during the inspection, the necessary changes had not been implemented quick enough. Since the provider had taken over the service in April 2022, service leads had not carried out any clinical audits to assess the quality of service delivery. The service had recognised this needed to improve and had recruited an internal auditor who was due to start their role in December 2022. The role was to enhance the services quality assurance processes and would be responsible to carry out routine audits, internal inspections and manage complaints, feedback and patient surveys.

Managers logged key risks on the service's risk register, but at the time of the inspection it was unorganised and did not clearly demonstrate the control measures in place to manage those risks. Following the inspection, we requested a copy of the risk register, and the provider sent us an improved version. The risk register had been reviewed and was clear to read. The provider's top risks included: workforce capacity for both the health visiting and school nursing teams to deliver the HCP, low staff morale, and the duty email inbox not being responded to in a timely manner.

Information Management

The service collected reliable data and staff could find the information they needed to inform them about the running of the service, but this information was not always used. The service had not completed notifications of reportable incidents promptly.

The service collected information, but it did not always review it fully. This had led, for example, to several families who had transferred into the service not being seen in accordance with the provider's policy. The team reviewed data relating

to the delivery of the Healthy Child Programme. The administration hub ran performance reports and shared them with service leads. The service was required to submit regular reports to the commissioners. During the inspection, we were told of an occasion where a performance report identified some families that had not received a new birth visit. The issue was followed up by the head of the service and the issue was addressed.

All services registered with the Care Quality Commission (CQC) are required to notify the Commission of certain incidents, without delay. Whilst the service had notified the CQC of three reportable incidents, the notifications had not been submitted within a reasonable amount of time. For example, one incident occurred in June 2022 and the provider had not submitted the notification to the CQC until November 2022. Another incident had taken place in September 2022 and the notification had not been submitted until November 2022.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Staff told us that they had been involved in conversations about service changes. The provider had implemented a 'you said, we did' board in the office base as way of engaging staff in service improvements and demonstrating that service leads were listening. The service was in the early stages of planning engagement with local service-user groups and partner organisations such as local GPs practices and midwifery liaison. The service had set up an outreach initiative called 'wheels on the bus'. The mobile bus unit was going to attend community venues and provide an opportunity for staff to engage with families and promote health and wellbeing.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

The service planned to start a 0-19 forum from December 2022. The meeting was an opportunity for the service to invite guest speakers, discuss clinical practice and undertake group training. The service recognised that delivering new birth visits (NBVs) as part of the Healthy Child Programme was the most demanding on the service. As a way of managing the demand and the lack of staffing, the service had developed a virtual wards model for the delivery of NBVs and had agreed with commissioners to pilot the model for six months in conjunction with a university. At the time of our inspection, we did not inspect this part of the service as the plans for the pilot were being finalised and the service was not yet operational. Following the inspection, the provider told us that the service had recruited experienced health visitors and had put systems and processes in place to triage and monitor the virtual wards contact children and their families received.

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
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not ensured that the Care Quality Commission was notified of all incidents requiring notification, without delay.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that clinical staff received regular clinical supervision and that all members of staff received the required mandatory training.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that they were continuing to improve performance in completing checks for the mandated milestones outlined in the Healthy Child Programme. The provider had not ensured that clinical records were up to date with important information and included rationale for clinical decision making.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Family planning services

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have robust governance and assurance systems in place to oversee and monitor the quality and safety of care and respond quickly to areas requiring improvement.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service had failed to ensure that robust safeguarding systems and processes had been put in place in order to ensure children, young people and their families were appropriately assessed, reviewed and identified risks were managed. Safeguarding systems and policies in place were not robust and staff who required safeguarding supervision did not receive this every three months with a qualified safeguarding supervisor.