Walsall Healthcare NHS Trust

RBK

Community health services for children, young people and families

Quality Report

Date of inspection visit: 1 May 2017, 20 – 22 June 2017, 4 July 2017
Date of publication: 20/12/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
		Mary Elliot Special School	Community health services for children, young people and families
LocationID	Location name	Walsall Child Development Centre	Community health services for children, young people and families
LocationID	Location name	Harden Health Centre	Community health services for children, young people and families
LocationID	Location name	Sai Medical Centre	Community health services for children, young people and families
LocationID	Location name	Blakenhall Village	Community health services for children, young people and families

Summary of findings

LocationID	Location name	Old Hall Special School	Community health services for children, young people and families

This report describes our judgement of the quality of care provided within this core service by Walsall Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Walsall Healthcare NHS Trust and these are brought together to inform our overall judgement of Walsall Healthcare NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Following the last inspection in September 2015, we rated the service as good overall. We rated effective, caring, responsive and well led as good and safe as requires improvement. This was because;

- Children, young people and families were at an increased risk of avoidable harm due to the numerous electronic systems in place to record information.
- Complete and robust information was not always available for multi-agency decisions about children at risk of abuse.

  Following this inspection we saw there had been improvements made in the effective domain, however we had concerns relating to areas within safe.

We have rated this service as good overall. This was because:

- We saw that there had been improvements since the last inspection with the storage and availability of patient records. Staff also told us that the patient administration systems were used more effectively for the needs of the services.
- We saw there had been improvements with lone working procedures and staff had either been provided with or offered mobile telephones to use whilst working in the community.
- Staff were clear of when to report incidents, knew the process to do so and we saw examples of appropriate investigations and learning from incidents across services.
- We saw many examples of excellent multi-disciplinary working and all staff told us this was very strong across all CYP services.
- We observed and families told us that compassionate care was provided by staff across the service.
- There was an open and honest culture and all staff we spoke with were patient focussed and motivated to provided quality care.
- The transition team had been nominated for three national awards and had been highly commended by the Health Service Journal in 2016.
- We saw innovative ways of working such as the 'little learners' group set up by speech and language therapists and the roll out of a minor illnesses app to support parents who may have concerns.

However:

- We saw that registered nurses had not completed or checked medication administration charts for children and young people (CYP) in special schools in accordance with the standard operating procedure (SOP). However, when we returned for the unannounced visit all of the charts had been checked and the SOP changed in accordance with the trust medicines policy.
- We saw that a piece of equipment at a patient's home was overdue for service by four months. Staff told us this had not been exchanged due to the patient being admitted to hospital however, we did not see evidence that risks of use of the equipment had been mitigated.
- We heard examples where staff had acted outside of the scope of professional boundaries.
- We saw that the completion of mandatory training topics including adult basic life support, fire safety and adult protection were below the trust compliance rate.

Summary of findings

Background to the service

Walsall children's community services provided a range of services for children and young people included:

- Community children's nursing service
- Child development centre
- Health visiting
- School nursing
- Children's occupational therapy
- Children's physiotherapy
- Children's speech and language therapy
- Health transition
- Teenage pregnancy
- Health in pregnancy service

The settings where care was delivered included schools, children's centres, community health centres and the children's own homes.

Between May 2016 and April 2017 a total of 9297 referrals were made to CYP services. This included:

- 6958 referrals to the health visiting service
- 1943 referrals to the school nursing service
- 9 referrals to health transition service
- 92 referrals to the children's hospital at home service
- 295 referrals to the community children's nursing service (including special schools)
- 332 referrals to the occupational therapy service
- 163 referrals to the physiotherapy service
- 348 referrals to the team around the child
- 2222 referrals to the speech and Language service

During the inspection, we attended a variety of these settings to observe care provided and speak with staff and patients. We conducted interviews with speech and language therapists, community children's nurses, health visitors, school nurses, assistant practitioners, managers and service leads. We spoke with 48 members of staff in total. We spoke with 14 children and young people using services and/or their parents or carers. We also reviewed 16 children's records which included individual care plans and risk assessments.

The health of people in Walsall is worse than the England average. Deprivation is worse than the England average and about 15,000 children live in poverty. Life expectancy for both men and women is significantly worse than the England average.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper, Head of Hospital Inspection, Care Quality Commission

Chair: Martin Cooper**,** Retired Medical Director, Royal Devon and Exeter NHS Foundation Trust

Team Leader: Angie Martin Care Quality Commission

The team included CQC inspectors, health visitors and a paediatric nurse.

Why we carried out this inspection

This inspection was carried out as part of the programme of scheduled focussed inspections. The trust is currently in special measures, following an announced comprehensive inspection on 8 to 10 September 2015.We also carried out three unannounced inspection visits after the announced visit on 13, 20 and 24 September 2015.

Summary of findings

Following the 2015 inspection, we rated this trust as 'inadequate'. We made judgements about eleven services across the trust as well as making judgements about the five key questions we ask. We rated the key questions for safety, effective and well led as 'inadequate'. We rated the key questions, for caring and responsive as 'requires improvement'.

After the inspection period ended, the Care Quality Commission issued the trust with a warning notice served under Section 29A of the Health and Social Care Act 2008. This outlined the quality of healthcare provided by Walsall healthcare NHS Trust for the following regulated activities required significant improvement:

• Diagnostic and screening procedures

• Maternity and midwifery services

• Surgical procedures

• Treatment of disease, disorder or injury

Due to the special measures status of the trust, we inspected all services at the main acute site, Manor Hospital. We also inspected community services: adult services, children and young people and end of life care.

How we carried out this inspection

We inspected this service in May, June and July 2017 as part of the focused inspection of the trust, which included community services for children and young people.

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an unannounced visit on 31 May 2017 and then visited announced on the 21 and 22 June 2017. We returned again unannounced on 4 July 2017.

We contacted key stakeholders to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades.

Before the announced visit, we held focus groups with a range of staff who worked in community services for children and young people to share their views.

During the inspection, we attended a variety of settings to observe care provided and speak with staff and patients. We conducted interviews with speech and language therapists, community children's nurses, health visitors, school nurses, assistant practitioners, managers and service leads. We spoke with 48 members of staff in total. We spoke with 14 children and young people using services and/or their parents or carers. We also reviewed 16 children's records which included individual care plans and risk assessments.

What people who use the provider say

The service asked for patients and parents/carers to participate in the friends and family test (FFT). Of those who took part, 90% said they would be extremely likely to recommend the service.

We spoke with people using the service who told us "staff are always available if answers to our questions are needed." And when telling us about their experience of

Summary of findings

playgroups held at the child development centre: “it’s a safe place where I can talk about my child’s problems without being judged because the staff and other parents understand where I am coming from”

Good practice

- The speech and language therapy team had won the NHS England Allied Health Professional Award for associate of the year 2017. This was specifically for the ‘little learners’ group initiative which involved 90 children, their parents/carers and teaching assistants.
- The transition team had been nominated for three national awards and had been highly commended by the Health Service Journal in 2016.
- Nursery nurses in the school nursing service had been nominated by schoolchildren for an educational video developed by the team called “help me I’m hairy”. They were able to train the trainers to deliver the content of the education sessions and were undertaking training sessions with teachers at the time of the inspection.
- The teenage pregnancy service had developed a website called ‘Easy SRE’, a toolkit of resources to support sex and relationships education.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- Ensure blinds cords are secured in all areas where children and young people may attend.
- Patient records are kept confidential and secure.
- Continue to follow standard operating procedures with medicines in special schools.

Action the service SHOULD take to improve

- The service should provide leaflets or posters to give information to families who may wish to raise complaints.
- The service should ensure all policies are reviewed and up-to-date.
- All staff members to keep within professional boundaries.

Walsall Healthcare NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as requires improvement for safe. This was because:

- We saw that the completion of mandatory training topics including adult basic life support, fire safety and adult protection were below the trust compliance rate.
- We saw that registered nurses within the community children's nursing team had not completed or checked medication administration charts for children and young people (CYP) in special schools in accordance with the standard operating procedure (SOP). However, when we returned for the unannounced visit all of the charts had been checked and the SOP changed in accordance with the trust medicines policy.
- We saw that a piece of equipment at a patient's home was overdue for service by four months. Staff told us this had not been exchanged due to the patient being admitted to hospital however, we did not see evidence that risks of use of the equipment had been mitigated.
- We heard examples where staff had acted outside of the scope of professional boundaries.
- During the first unannounced inspection, we saw that blind cords at the child development centre were not secured to the wall and could pose risks to children and young people using the rooms. When we returned for the announced inspection, we saw that blinds were all secured aside from one room.
- We saw school nursing waiting times of up to five months for routine patients and six weeks for looked after children and those with a child protection plan. The service sickness rate was 7%, which was above the trust target of 3.39%.

However:

Requires improvement

Are services safe?

- We saw that there had been improvements since the last inspection with the storage and availability of patient records. Staff also told us that the patient administration systems were used more effectively for the needs of the services.
- We saw there had been improvements with lone working procedures and staff had either been provided or offered mobile telephones to use whilst working in the community. However, nursery nurses working within the health visiting teams told us they had recently been asked to hand theirs back and so were using their personal mobile telephones when necessary.
- Staff were clear of when to report incidents, knew the process to do so and we saw examples of learning from incidents across services.
- We saw that root cause analysis was conducted following serious incidents and the example we saw was completed in a robust and timely manner.
- Staff were aware of the process for raising safeguarding concerns and we saw examples of where they had done so and received support from the relevant teams.

Detailed findings

Incident reporting, learning and improvement

- Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between April 2016 and March 2017, the service had not reported any never events.
- One serious incident occurred in June 2016 and involved the theft of equipment that contained patient identifiable information. We saw the root cause analysis investigation report, which had been conducted in a timely and comprehensive manner. This included an action plan to prevent this from happening again and for support for the families who may have been affected.
- There was a trust wide electronic incident reporting system. Staff we spoke with told us they were encouraged to report incidents and were able to access this system to do so. Staff gave us examples of incidents they had reported and outlined feedback received and changes to practice because of learning from these.
- Data provided by the trust showed that between April 2016 and March 2017 there had been 56 incidents reported across the community children and young people's service. Of these, one was graded as minor harm to a staff member and involved a needle stick injury. All of the other incidents were graded as no harm.
- Staff knew how to report incidents and told us that they received feedback when they had done so. Staff and managers told us that learning from incidents was discussed during staff meetings and that this included incidents across services and locations as appropriate.
- An example given of action taken following an incident included locks put on doors at the child development centre following a child having opened the door during a clinic.

Duty of Candour

- 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.
- Staff we spoke with described their obligations under duty of candour and provided examples of where this had been put into practice. We saw that letters had been sent appropriately and meetings offered in accordance with the regulation.

Safeguarding

- In March 2014, the Royal College of Paediatrics and Child Health published the Safeguarding Children and Young People: roles and competence for health care staff, Intercollegiate Document. The document defines the level of child safeguarding training that is required for various staff groups. The trust policy stated that, in line with this document, all staff working in CYP services should receive children's safeguarding training as appropriate to their role as part of their mandatory training programme. Data from the trust showed that 89% of staff had completed level 3 safeguarding training, against a target of 90%.
- Data provided by the trust showed that during the reporting period 460 safeguarding referrals had been made across CYP services in accordance with their policy.
- All of the staff we spoke with were familiar with the trust safeguarding policy and how to access this. They were

aware of the procedure to follow if they had safeguarding concerns and knew the safeguarding lead. We saw safeguarding posters on display in the clinical bases.

- Staff told us they kept up-to-date with national and local changes in policy and procedure and were supported with this.
- We saw that there was a team of named nurses for safeguarding across CYP teams who provided peer support and supervision as required. Staff working in the CCN team told us that they had not had safeguarding supervision for over six months due to staffing issues within the safeguarding team however felt they could receive support from them if it were required.
- School nursing and health visiting services had their own supervisors who were trained through a national children's charity and so had received regular supervision.
- The increasing demand on the school nursing team due to safeguarding concerns was on the service risk register with a potential for the inability of staff to attend initial child protection case conferences. The service was mitigating this risk with ongoing monitoring of staff caseloads and prioritisation.
- We saw that there were seven recorded incidents in the reporting period where a member of the safeguarding team could not attend the Multi-Agency Safeguarding Hub (MASH) due to capacity within the team.
- The lead for the teenage pregnancy service sat on the panel for child sexual exploitation to raise or receive concerns about children and young people. Staff told us they had received training in awareness of female genital mutilation (FGM) and showed good awareness of relevant issues. FGM awareness was included in the trustwide level 2 and 3 safeguarding training. Staff working in the health visiting and school nursing services had also attended multi-agency FGM training provided by the local authority.
- There were flags in place to alert staff when there was a child protection concern, which the team kept up-to-date. For example, if a child had a child protection plan in place, this would trigger an alert.
- A review of referrals took place in 2016 with the aim to improve safeguarding outcomes. The results of this led to increased staffing of medical staff until 6pm as the referrals increased in numbers up to this time.

A representative from the Health Visiting and School Nursing service attended 'Early Help' locality meetings where the needs of children and young people identified as being in need of additional support were discussed.

Medicines

- We saw that fridge temperatures in special schools were checked daily and that records showed these had remained within acceptable levels.
- We saw that all children in special schools who required medicines had their own box that was double locked. The medicine cupboard was triple locked. Due to lack of opportunity, we did not see any administration of medicines to children.
- We saw that all medicines contained in the cupboards in special schools were within their expiry date.
- Three out of four assistant practitioners had started a Level 2 Certificate in understanding the safe handling of medication in health and social care course.
- Assistant practitioners had administration of medicines competencies signed off by a community children's nurse annually. We saw that at the time of the inspection all of the assistant practitioners were signed off as competent. However, we had concerns that there was no evidence of this held at the base or schools and so it was difficult for the manager to clearly see the dates that competencies needed to be reviewed. When we returned for the unannounced inspection, there was a folder available to evidence all of the completed competencies and a clear spreadsheet that showed the dates when these required a review.
- We saw that the SOP for managing medicines including controlled drugs in special schools by the community children's nursing (CCN) service stated "all medication to be recorded on individual CYP medication administration chart by a registered nurse". However, we attended two special schools and found that across the two sites 30 charts out of 71 were unsigned by a registered nurse. When we returned for the unannounced inspection, the SOP had been changed to read "all medication to be recorded on individual CYP medication administration chart by an assistant practitioner (AP) and checked and signed by a registered nurse (RN)". This was in line with the medicines policy in place at the time of the inspection. We attended one special school and saw that all of the charts had been checked and signed by a RN and staff told us that this was also the case at the other sites.

Requires improvement

Are services safe?

- We saw that when administering medicines the APs would prepare them on their own and would ask a teacher to witness them being given to the CYP and sign the records. Teaching staff confirmed the identity of the child in the classroom and the APs also had a picture of the child as a second safety check.
- There was one nurse prescriber in the CCN team and we saw that FP10 prescriptions were taken out on home visits and to the staff members own home. We had concerns about the security of these prescription sheets and the lack of guidance available in the trust policies and procedures for managing these. When we returned for the unannounced inspection we saw that the nurse prescriber had locked the main prescription pad in the office when not in use and only took the necessary amount of prescription sheets on home visits.
- We saw the care quality indicators dashboard for the CCN team that showed an average compliance of 95% in May 2017. All scores aside from one were compliant including allergy status on each chart, medication cabinets locked and daily temperature recordings completed. Two out of three medicine fridges were locked that gave a non-compliant score of 67%, staff explained that one fridge did not have a lock on it but did not contain any medicines (as there had been no children or young people that required refrigerated medication yet) so the school had not provided a lockable fridge.

Environment and equipment

- We saw that children's clinics were provided in age appropriate settings.
- We looked at the storage, maintenance and availability of equipment used in clinics, children's own homes and in schools. Staff told us equipment was easy to access and in good supply.
- We saw evidence that weighing scales used in school nursing and health visiting teams were cleaned and calibrated appropriately in accordance with the local policy and equipment used during home visits were also serviced according to trust policy.
- During our unannounced visit, we saw that in the child development centre there were blinds with loose cords unsecured in areas where young children would attend. We raised concerns about the ligature risks with these cords. When we returned for the announced inspection, the blinds had been secured however; we saw that in one room there was no tieback so the cords were still loose. Staff told us this room was not usually attended by children however during the inspection a meeting was held in this room and a child attended. Staff told us that children were not left in this room unattended.
- We saw evidence that equipment for children under the care of CCNs was serviced annually. We saw that a suction unit was due to be serviced in January 2017 however had not been checked. We raised this with staff who explained that this had not been done as the patient had been in hospital and staff had not carried out any home visits since the equipment service was due. We did not see evidence that the family had been informed about the potential risks of using the equipment or attempts to arrange the exchange of it. When we returned for the unannounced inspection, we checked the records and saw that this equipment had been exchanged and serviced.

Quality of records

- CYP teams all use paper records. For patients regularly using services, records were kept at the appropriate bases. For archived records or those who were seen infrequently, there was a storage centre for records and staff would access these as required.
- The standard operating procedure for the transportation of notes outlined that staff should not take patient notes with them unless necessary and then to take the minimum required. Potential breach of the information governance policy was on the service risk register.
- The community children's nursing (CCN) team used paper records that they transported to visits and the base in postal bags in the boot of their cars. We reviewed the standard operating procedure for records that stated that if the CCN was not returning to the office at the end of the day then the postal bag with patient records must be taken to the CCN's house for safekeeping overnight. Staff were following this procedure however told us that it could be a number of days before the records were returned to the office. We were not assured by this that records were kept confidentially and that staff would always have access to them when required.
- At the time of the inspection, there was a trust wide plan for community services to use electronic records. This was due to be piloted in the months following the inspection.

Requires improvement

Are services safe?

- We saw the electronic patient administration system in place and staff told us there had been improvements with this since the previous inspection and that they used it to meet the requirements of the teams.
- During the inspection, we reviewed 16 records across the services. We found that these contained relevant information and were legible, up-to-date with consent documented.
- The CCN service conducted monthly record keeping audits. Results of these showed that compliance between October 2016 and May 2017 was 93% on average. In October 2016 only 20% of records audited included a signature sheet however by May 2017 92% did. Other improvements included page numbers being in order at 78% in November 2016 to 95% in May 2017.
- The school nursing service conducted an annual record keeping audit. The results of the 2016 audit highlighted areas for improvement that included not leaving blank spaces, including the time of writing, and NHS number to be written on pages contained in records. The service achieved 100% for completion of patient name and date of birth.
- An annual records audit was completed for speech and language therapy in October 2016. This showed storage of records to be 100% compliant. We saw that 12% of records were not completed in black ink and 84% did not have a page number on every page and so were highlighted as areas that needed improvement.
- Health visitors told us that if a patient attended a clinic whose notes were held by another team, they would email them to the relevant health visitor through the trust secure email account.
- An incident had occurred where the diary of a staff member had been stolen and this had contained patient information. Because of this incident, staff either used electronic diaries or only included the minimum information required and did not include patient names.

Cleanliness, infection control and hygiene

- All of the clinic rooms and waiting areas we visited appeared to be clean with well-maintained furnishings. We saw cleaning records that showed staff regularly cleaned these areas. Staff cleaned rooms and equipment in between sessions as well as a daily deeper clean.
- All of the areas we saw used by nursing staff in special schools were clean and we saw cleaning schedules.
- All staff were required to participate in infection control training. Data provided showed that at the time of the inspection 91% of community CYP staff had completed this training.
- We saw all staff were 'arms bare below the elbows' and washed their hands between patient contacts. We saw examples of handwashing audits completed with the health visiting team that identified issues such as an inadequate supply of hand gel picked up in the July 2016 audit with the Sai Health Visiting team. The most recent handwashing audit took place at Parkview and showed 97% compliance.
- Cleanliness audits were completed at the child development centre. We saw the report for March 2017 that showed a compliance score of 83%. Actions included the requirement of a standard operating procedure to outline staff responsibility for cleaning equipment and toys. We saw that this had been put into place prior to the inspection. Toys were visibly clean and staff told us they were cleaned a regular basis.

Mandatory training

- The trust had a mandatory training programme for staff that various topics including conflict resolution, equality and diversity, information governance and infection control.
- Staff and managers told us there was protected time for completion of mandatory training and that they were well supported to participate in training sessions.
- At the time of the inspection, the compliance rate for mandatory training overall was 86%. The service was non-compliant with adult basic life support (77%), fire safety (67%) due to changes in the training requirements, for the period April 2016 to March 2017. Staff were completing catch up sessions at the time of the inspection.

Assessing and responding to patient risk

- We saw information in patient care plans to guide parents and carers in the event of an emergency of if the child or young person's condition deteriorated. If urgent medical treatment was required then families would call emergency services.
- We saw the use of risk assessments across CYP services to assess and manage individual risks to children. For example, the transition team used a risk assessment prior to young people participating in activities and

clearly outlined the procedures to follow in the event of more likely risks occurring. If children were taking part in activities at special schools, the appropriate risk assessments were completed prior to them doing so.
- We saw that where appropriate, the Malnutrition Universal Screening Tool (MUST) was completed as part of assessing a child or young person's nutritional risks.

Staffing levels and caseload

- We saw that the CYP service had sufficient staff to meet the demands of patients and their families.
- There was one full time nursing vacancy within the community children's nursing team at the time of the inspection. This vacancy was out to advert at the time.Staff told us this had impacted upon the team and that often patients would be required to wait to be seen the following day if staff had to prioritise a patient at risk. Staff told us they were managing their workload appropriately and although they would often work for over an hour longer than their shift, they would get the opportunity to take this time back as the service reduced working hours on some days to compensate for the lower staff numbers. The CCN team did not use a staffing tool to ensure that there were adequate staffing levels and skill mix.
- We saw that assistant practitioners working in the community children's nursing team wore different coloured t-shirts as uniform. In the acute setting, the uniform colours refer to grade of staff however this was not the same in the community. This meant that teaching staff in schools or other agency staff were often mistaken in thinking that assistant practitioners were registered nurses.
- The planned whole time equivalent (WTE) staffing level for paediatric physiotherapy was 7.84 but the actual figure was below this at 6.44. Planning levels for occupational therapy was 5.97 and actual was 4.93. Staff told us they had set up group work and prioritised cases in order to manage with less staff than required.
- The planned level for speech and language therapists was 20 WTE and this service was fully established at the time of the inspection.
- There were five community paediatricians working for the trust. There were approximately 500 referrals to the child development centre and staff told us these ratios were sufficient.
- At the time of the inspection there were 55 WTE health visitor posts filled. The vacancy rate was 3.32 WTE. There were also 12 WTE nursery nurses in post.
- The community practitioners and health visitors association recommended that each health visitor should hold a caseload of up to 300 families or 400 children. We saw that caseloads of health visitors met these recommendations as health visitors had an average caseload of 346 children.
- The health in pregnancy service (HIPs) was staffed by one WTE Band 7 and 2.6 WTE Band 6 health visitors and seven band 3 and 4 staff.
- Staffing levels had reduced in the 0-5 years healthy child programme and so the team were implementing an increased skill mix model at the time of the inspection.
- We saw school nursing waiting times of up to five months for routine patients and six weeks for looked after children and those with a child protection plan.. A review of the referral process had taken place and many children and young people had been allocated to parent workshops which had helped to reduce the waiting times. The service triaged referrals at the point of receipt to risk assess, sign post to other agencies where appropriate and to identify those with priority needs.
- The teenage pregnancy service consisted of a full time band 7 operational lead, one part time (0.4 Whole Time Equivalent) support worker and one part time (0.8 Whole Time Equivalent) administration assistant.
- The sickness rate for staff across community CYP services was 7%, which was worse than the trust target of 3.39%.

Managing anticipated risks

- The trust had a lone working policy in place and staff showed us how to access this on the trust intranet. Lone working was on the service risk register.
- Staff told us they used a "buddy" system when lone working and kept in touch to ensure other staff members knew where they were whilst working out in the community.
- Staff working in the community children's nursing team gave us two examples where staff had acted outside of the scope of professional boundaries. These activities went against the 'promote professionalism and trust category in the Nursing and Midwifery Council's Code 2015. This states that nursing staff should 'stay objective and have clear professional boundaries at all times with

Requires improvement

Are services safe?

people in your care (including those who have been in their care in the past), their families and carers'. The activities posed risks to the staff and the patients and their families.

- The community children's nurses all had a mobile telephone provided by the trust. Senior managers told us that all therapists had been given the choice of having a phone provided.
- Nursery nurses in the health visiting teams told us they had been provided with a mobile phone by the trust but had recently been told to return these and so were relying on using their personal telephones whilst lone working. Managers told us mobile telephones were due to be issued back to nursery nurses, but no timeframe was given.
- Staff told us they had taken part in fire safety training and were clear of the protocol to follow in the event of a fire. However, data provided by the trust showed that only 67% of staff in the community CYP department were up-to-date with this training, for the period April 2016 to March 2017.
- Staff told us they were aware of the trust's major incidents policy but told us they had not received specific training. However, during adverse weather conditions staff were aware of how to prioritise visits for children and their families.

Good

Are services effective?

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

We rated this service as good for effective. This was because:

- We saw that across all services staff provided evidenced based care and treatment.
- Staff across services followed processes to ensure the nutrition and hydration and pain needs of children and young people (CYP) in their care were appropriately assessed and managed.
- We saw that audits were conducted that were reflective of the needs of local people for improving services.
- We saw evidence that outcomes for patients were good including health visitor contacts and reduction in the teenage pregnancy rates following introduction of support services and educational programmes.
- We saw many examples of excellent multi-disciplinary working and all staff told us this was very strong across all CYP services.
- We saw evidence of staff competencies checked and that training needs were managed well with staff provided with time and pay for additional courses that would benefit their role.

However:

- The transition policy required review and update.

Detailed findings

Evidence based care and treatment

- The policies and procedures used by children and young people (CYP) services were based upon national guidelines. Policies were available on the trust intranet system and we saw that staff knew how to access them.
- The health visiting and school nursing services followed the Department of Health national initiative called The Healthy Child Programme. The programme required the early intervention of health visitor contacts with babies and children. It offered regular contact with every family and included a programme of screening tests, developmental reviews and information, guidance and support for parents.
- We saw that health visitors gave information to parents in line with the Healthy Child Programme.
- The Health In Pregnancy service (HIPs) provided an antenatal programme founded upon a national evidence based programme with a view to decrease the higher than average infant mortality rate in Walsall. This linked well to the parenting programme led by health visitors and the HIP team.
- We saw that the community children's nursing (CCN) team used clear end of life pathways. We saw that these followed the West Midlands palliative care toolkit, resources based upon nationally resourced and researched sources. Children with long-term conditions were supported by individualised care plans based on evidence-based guidelines.
- Workshops to support parents with a range of issues ran from the child development centre and were based upon nationally recognised and evidence based programmes including Sleep Scotland.
- Looked after children received an initial health assessment by a paediatrician within 28 days in line with the National Institute for Health and Care Excellence (NICE) guidelines for looked after children and young people.
- A NICE baseline compliance review of improving maternal and child nutrition NICE quality standard 98 was conducted in 2015. This showed the 0-5 years-service to be partially compliant. To be fully compliant the service required healthy eating service pathways to be in place, we saw that these were at the time of the inspection.

Pain relief

- We did not observe pain relief being administered during the inspection.
- We saw that there were clear guidelines that reflected national guidance for staff to follow where pain management was appropriate.
- There were care plans in place to support children and young people who required pain relief in their own homes and in special schools.
- We saw in patient records that a child friendly pain scale was used to assess the child's level of pain.

Nutrition and hydration

Good

Are services effective?

- Health visitors provided healthy child clinics and the school nurses promoted healthy eating.
- The multidisciplinary paediatric dysphagia team provided support for children and young people with feeding and swallowing difficulties.
- Nutrition and hydration care plans were in place for children across special schools and at home.
- We observed a speech and language therapist following up discussions with a parent about the child's diet and checking if there had been improvements in the variety of food eaten since the previous appointment.
- We saw a dietician attend a team around the child meeting and discuss the nutrition and hydration needs of the patient.

Patient outcomes

- Data provided by the trust showed that between April 2016 and March 2017 93% of new birth visits were completed within 14 days. Ninety one per cent of health visitor six to eight week contacts were taking place before eight weeks. The health visiting team had completed 84% of 12 month reviews before 12 months, 95% before 15 months. We saw that 91% of 24-26 months examinations were completed by 30 months.
- The teenage pregnancy team produced a report to reflect performance in 2016. This showed that a total of 302 females aged 14 to 19 had been referred to the service. Six 'teens and toddler' programmes had been delivered by the teenage pregnancy service between March 2014 and June 2015. Data across Walsall showed that the teenage pregnancy rate had reduced by 29% over this time.
- A quality improvement audit on sleep management in children with autism spectrum disorder under 19 years of age within the trust was conducted in 2017. The audit found that 24 of 31 children reported sleeping difficulties, none had a detailed sleep history as advised by NICE guidelines and 11 of these 24 children were taking medication to help sleep. There was no evidence of behaviour interventions prior to the prescription of medications. The results from this audit led to the development of a sleep management service.
- The breastfeeding initiation rate between June 2016 and May 2017 was 66%, which met the CCG target (which was also 66%).
- We saw that 88% of initial health assessments for looked after children were completed within the national target of 28 days.

Competent staff

- Staff told us they had a six monthly personal development review (PDR) and yearly appraisal. They told us that targets were set around their caseload and that this was a useful and supportive process. Data provided by the trust showed that 87% of staff working in the CYP services had completed an appraisal which was worse than the trust target of 90%, for the period April 2016 to 60 March 2017.
- Staff working in the therapies teams told us they had one to one supervision every six weeks. Managers told us this was more regular for staff still in the preceptorship period.
- Health visitors told us they had one to ones with their managers every six weeks. Those in the preceptorship period had monthly one to ones.
- The therapy teams also had a team PDR where objectives were set and training needs arose from this to ensure staff were competent and confident.
- Staff told us competencies were checked against the Royal College of Nursing competency framework and were in place for all staff.
- We saw that staff who were new to the trust went through a comprehensive induction programme that included mandatory training. CCNs told us that new members of their team attended a study day and were supervised with clinical procedures new to them until they were assessed as competent.
- Community children's nurses told us they had participated in training days at the local children's hospital and with external companies. The training had helped to develop clinical skills and competencies. They told us they were well supported to complete any available training and that the trust would usually pay their time and for the course if this was reasonable.
- Staff told us they were well supported with the revalidation process.
- We spoke with staff who had completed Master's degree level qualifications at a local university who told us they had been encouraged and supported to do so.

Multi-disciplinary working and coordinated care pathways

- We saw there were communication pathways between services and the local authority for joint cases.
- Members of the CYP service had been involved in pathway work with Public Health England.

Good

Are services effective?

- Staff told us there had been improvements with the communication between CYP services and Children and Adolescent Mental Health Services (CAMHS). Regular meetings were held and staff told us they felt there was a positive working relationship, which helped with referrals and discussion of children and young people who required input from a variety of specialists.
- The transition team had worked with local youth groups and activity coordinators and set up a scheme where young people could arrange to attend various activities during school holidays with the support of the transition team.
- The community children's nursing (CCN) team had developed strong links with specialist nurses at the local specialist children's hospital. Staff told us they could contact them for advice and support when required and had comprehensive handovers when a patient was discharged from the hospital into the care of the community children's nursing service.
- Staff told us there was a good working relationship with the local hospice and we saw evidence of effective joint working in patient records.
- Services worked with the team around the child (TAC) philosophy which had the mission statement "Tell your story only once, Access to Professionals and Child and family outcome focussed."
- The TAC panel met weekly to discuss new referrals and if there were changes to children already receiving care from services. Staff told us this was a productive and effective way of working and ensuring children's needs were being met.
- We saw that pathways were in place for CYP including for those diagnosed with Down's Syndrome, long-term conditions and who had special educational needs (SEN).
- We saw a referral pathway was established for the teenage pregnancy service.
- A GP engagement day had been arranged for CYP services (acute and community) to showcase their work and inform of appropriate referral processes.
- There was a named community children's nurse for each school for children with severe learning difficulties in the area. The nurse would attend the school on a weekly basis to pick up any issues raised by pupils or staff. Assistant practitioners were based in these schools where the children and young people on their caseload would attend.
- Every school in Walsall had a named school nurse and liaison visits took place on a termly basis to ensure schools were updated on service provision and priorities.
- A paediatric liaison nurse was in post, which had strengthened the links between the acute and community services.
- A multi-agency transition meeting was held monthly in addition to a monthly palliative care meeting.
- The teenage pregnancy service delivered the national government 'teens and toddlers' programme in partnership with the local authority.
- Staff were trained to deliver the 'Cygnet Parenting Programme' in partnership with the local authority and other health professionals.

Referral, transfer, discharge and transition

- Referral arrangements were in place and staff told us the processes were effective. For example, we saw records where CYPs were under the care of the CCN team and were referred to physiotherapy and speech and language teams.
- There was a dedicated transition team for young people and young adults who worked with 14-25 year olds with significant physical impairments. The aim of this service was to support and guide service users through the transition between CYP to adult services.
- The transition team worked with young people to complete a health passport. This was for young people to take with them across services and so they did not have to go through all of the same information at all their different appointments. We saw an example of a health passport that included all of the young person's health and social care contacts so they could use it as a clear reference guide when resolving any issues or for getting information.
- We saw that there was a comprehensive operational policy in place for transition however, this was overdue for review and the copy available for staff on the intranet was not dated. Staff told us this was being worked on at the time of the inspection as well as a trust wide transition policy. There was an up-to-date transition pathway in place.
- The community children's nursing team supported young people with transition to adult services. This

process started from the age of 14 with adult services taking over by the age of 19. The named nurse and assistant practitioner would attend meetings to assist with transition as they reached the appropriate age.

Access to information

- Staff showed us how they accessed policies and procedures as well as other information essential for their role on the intranet. Bases also had printed out copies for those that required regular use.
- At the time of the inspection, we saw that the standard operating procedures held in a folder at the community children's nursing base were out of date. The revised and updated versions were available on the trust intranet however, we saw that these were not very easy to access and had not been signed as read and agreed to by the staff. During the inspection the folder was updated with the latest versions and we saw at the unannounced inspection that these had all been signed by the staff and were accessible to staff.

Consent

- Services sought the consent of children and young people when providing care and treatment. This 'Gillick Competency Assessment' helps clinicians to identify children aged 16 or under who have the legal capacity to consent to medical examination and treatment. Staff told us that Gillick competency assessment was used where appropriate. All staff we spoke with understood their roles and the need to gain consent.
- During our observations we saw that children, or where appropriate their parent/carer, were asked for consent prior to any care or examinations conducted. This was documented in all of the patient records we saw.

Good

Are services caring?

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

Summary

We have rated this service as good for caring. This was because:

- Results from the friends and family test showed that 90% of respondents would be extremely likely to recommend the children and young people (CYP) services.
- We observed and families told us that staff provided compassionate care across the service.
- We saw that the services were patient focussed and staff ensured the child or young person in their care and their families understood their diagnosis and on-going treatment.
- We observed staff reassuring the child or young person and their parent/carers and provided emotional support.

Detailed findings

Compassionate care

- Children and young people (CYP) services participated in the Friends and Family Test (FFT). This indicated how likely a member of the public would recommend the service to a friend or family. The scored for CYP services showed that 90% of those who responded said they would be extremely likely to recommend the services to their friends and family.
- We observed interactions across CYP services undertaken in a dignified and compassionate manner.
- We spoke with 14 CYPs and their parents/carers who all told us the staff were friendly and caring.
- We spoke with a parent whose child had been receiving care from the community children's nurses at home. They told us they had felt reassured by the team and that the nurses were very caring at all times.
- Staff gave examples of how they provided compassionate care and told us they always took the time to ensure the CYP was comfortable and at ease before providing care and treatment. For example, we observed during a school nursing health assessment the nurse spent time talking to the young person about their aspirations for the future and what was happening in their life prior to conducting any specific health assessment.

Understanding and involvement of patients and those close to them

- We saw many examples of child-centred care being provided across CYP services. We saw children and parents involved fully in consultations and reviews. Examples included a consultant playing with a child prior to and during assessment and sitting on the floor with them to check eye contact and maintain engagement.
- We saw feedback from parents and carers displayed which included "Staff are always available if answers to our questions are needed."
- We observed information provided by a community children's nurse during a constipation clinic. We saw this was provided with a person centred approach and there was good communication between the staff and young person.
- We saw a paediatric consultant explain a treatment plan and rationale for further tests to a parent. This was patient focussed, clear and fully involved the family.
- Feedback from parents included; "my son has been under occupational therapy for over a year and we are really pleased with the professional service. We have learnt many strategies and received excellent advice and feedback. Occupational therapy have put time and effort into helping us".
- We spoke with a young person who had taken part in activities organised by the transition team who said, "I enjoy going to the youth group and doing activities. The team help me to be independent and meet other young people".

Emotional support

- During an observation of a speech and language therapy session we saw reassurance given to the patient and parent and staff take the time to listen to the concerns raised.
- Staff told us they worked to support patients and their families as much as possible. Examples of this included referral to agencies outside of the health service if it would assist the family such as through education or support groups.
- We spoke with parents who attended specialist playgroups who told us they had received a lot of

Good

Are services caring?

emotional support from staff and that this had made a big difference to them when going through difficult times with their child's diagnosis and ongoing treatment. One parent said, "It's a safe place where I can talk about my child's problems without being judged because the staff understand where I am coming from".

- We spoke with people who attended initial health assessments with the school nursing team. One young person told us that he had felt nervous before attending the appointment but felt better after meeting the staff.
- One young person who had used the service told us the care provided was "absolutely brilliant, so professional. They saved me."

Good

Are services responsive to people's needs?

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

Summary

We have rated the services as good for responsive. This was because:

- Children and young people (CYP) services were planned and delivered to meet the needs of the local population.
- We saw that staff were considerate and flexible with meeting the equality and diversity needs of the families accessing services.
- We saw group sessions met the needs of those in vulnerable circumstances such as young carers.
- We saw that the CYP service was responsive to concerns raised by families and that learning had taken place as a result. This included staff in the therapies team arranging for those with concerns to have a 'named contact' to help with communication.
- We saw that 88% of looked after children had an initial health assessment within the national target of 28 days.

However:

- There were no leaflets available to provide families with the information they may require when raising concerns for example the details for the patient advice and liaison service (PALS).

Detailed findings

Planning and delivering services which meet people's needs

- Services for children and young people (CYP) were commissioned by public health. Professional leads and care group managers told us that they attended meetings with commissioners on a quarterly basis.
- The school nursing team delivered a total of 2830 contacts during the reporting period.
- The community children's nursing (CCN) service was available Monday to Friday 8am to 8pm and Saturday, Sunday and bank holidays 8am to 4pm. At the time of the inspection, the service was running some days 8 am to 6 pm due to reduced staffing levels. If a patient outside of these hours required treatment, they were advised to contact the Paediatric Assessment Unit at the acute hospital or the emergency services if appropriate.
- We attended home visits with the CCN service team and saw care delivery was individualised to meet the complex needs of children and support for the parents. We saw that the team worked hard to attend at a time that best suited the family.
- The child development centre had set up a specialist playgroup for children who found regular playgroups unsuitable. Staff trained in Makaton (a type of communication designed to support spoken language) assisted with communication and provided support for parents and carers.
- A sensory room with a range of stimuli that helped children engage their senses and aid development was available at the child development centre.
- Sleep workshops took place to assist families with sleep issues on an ongoing basis with three staff members having completed sleep counselling training.
- The child development service held workshops to assist parents of children with special educational needs and disability aged 0-5 such as toilet training.
- A nurse led tongue-tie (where the strip of skin connecting the baby's tongue to the floor of their mouth is shorter than usual) service was available and supported by an ENT consultant.
- Staff told us they were able to book interpreters to attend for a wide range of languages when required.
- A 'short breaks' scheme had been set up to provide respite for children with additional needs. This comprised of various sessions held at the child development centre with staff from therapies running activities.
- Staff trained in Makaton (a form of sign language used to help communication) led training sessions for parents and staff working in education settings.
- We saw that information leaflets provided by community children's nurses had been adapted to be child friendly. We saw these provided to patients during clinics. Staff also signposted patients and their family members to relevant websites for more information if they required it.

Equality and diversity

- We saw staff were considerate in meeting the religious needs of families. For example during one observation a

speech and language therapist discussed the impact of Ramadan with the family and ensured that the arrangements for the following appointment were sensitive to their needs at that time.
- Staff told us and we saw that interpreters were available when required for appointments. Staff told us it was easy to book an interpreter and that this did not create issues for them.
- Data provided by the trust showed that 88% of staff in CYP teams had completed equality and diversity training, which was worse than the trust target of 90%, for the period April 2016 to March 2017.

Meeting the needs of people in vulnerable circumstances

- The 'team around the child' approach used by the service worked effectively to ensure all of the professional support required by each child or young person was in place.
- The therapy team had set up a session called "little learners". This was a group setting for children with specific needs to spend time with therapists and attend with their teaching assistants and family members. It was an opportunity for staff to provide support for those assisting the children in other settings.
- The teenage pregnancy service had identified a peak in pregnancy rates following the summer school holiday following year nine. The service had organised sessions to take place at secondary schools for this age group with multi agencies including child sexual exploitation street teams, Brook, and substance misuse teams attending to provide education, advice and support to pupils. Evaluation forms completed by participants showed over 40 out of 50 who attended said they had learnt "a lot" from each session held in July 2016.
- The teenage pregnancy service had worked with the psychology team and developed an information leaflet focussed on healthy relationships. This was language and style appropriate for young people who may be at risk of forming unhealthy relationships and require support.
- The school nursing service had a young carers champion who supported children and young people who had a caring role for a family member. It was identified at the time of their health assessment if a young person was a carer. A young carers group was co-ordinated by school nursing teams. This service followed the department of health's gold standard framework.
- There was a specialist health visitor for asylum seekers and traveller communities. They worked with the local authority, police and border agencies and held clinics flexibly to meet the needs of those who required the service.

Access to the right care at the right time

- The children's community nursing service operated seven days a week between 8am and 8pm. This meant that CYPs could be seen before or after school, when preferred by families and we saw that they were flexible and accommodating to do this wherever possible.
- When patients were at the end of their lives the CCN team provided care seven days a week, 24 hours a day. This was organised on an individual patient basis by the team with a rota devised to ensure care was in place.
- A duty health visitor was available for contact on the telephone from 9am to 5pm Monday to Friday. If they were required to go out on a visit due to a call, a nursery nurse would cover the telephone to provide advice or take information.
- The Health in Pregnancy Service supplemented the trust maternity service. Staff led an antenatal programme with a view to decrease the higher than average infant mortality rate in Walsall. At the 12-week scan, women were given a questionnaire, which was revisited at the 20-week scan. This identified those women who may benefit from additional support and information. At the time of the inspection, the service had 119 women referred.
- The school nursing service evidenced a robust referral process and triage to ensure that the CYPs who required care as a priority were seen in a timely manner. This included a multi-disciplinary early help panel that took a holistic approach to support vulnerable children and young people.
- Data provided showed that 66% of looked after children had an appointment with the school nursing team within eight weeks of a health assessment.

Learning from complaints and concerns

Good

Are services responsive to people's needs?

- Data provided by the trust showed that during the reporting period one formal complaint had been received for community CYP services. This was about school nursing and concerns about referral to appropriate services.
- Staff were aware of the patient advice and liaison service (PALS) available for parents or carers who wished to raise concerns.
- Staff we spoke with were aware of the trust complaints policy and able to access this through the intranet. Staff provided us with examples of concerns raised by users of the service and changes made because of the complaints raised.
- Staff in the therapies team told us that they had managed a number of issues where parents or carers were frustrated by speaking to several different staff members about queries or concerns. This led to the team designating a named contact to deal with each complaint raised so that communication would improve and reduce the frustration for family members. Staff told us this had led to improvements with the timeliness and effectiveness of managing concerns and feedback from families had been positive.
- There were no leaflets or posters to advise patients of the complaints process or PALS during the inspection. Staff told us they could print this information if required but would usually provide the contact details.

Good

Are services well-led?

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

Summary

We have rated this service as good for well-led. This was because:

- Staff we spoke with spoke highly of their local managers and felt comfortable if required to raise concerns.
- There was an open and honest culture and all staff we spoke with were patient focussed and motivated to provide quality care.
- The service engaged well with the public to work towards planning services and working with a range of agencies and providers to do so.
- The transition team had been nominated for three national awards and had been highly commended by the health service journal in 2016.
- We saw innovative ways of working such as the 'little learners' group set up by speech and language therapists and the roll out of a minor illnesses app to support parents who may have concerns.

However:

We had concerns about some of the activities staff within the community children's nursing (CCN) team told us had taken place with children and young people in their care. Some examples given had been clear that staff did not have a full understanding of professional boundaries and risk management.

Detailed findings

Leadership of this service

- The community children and young people's (CYP) service was part of the integrated children's and families' care group. This was led by a Divisional Director of Nursing , Children, Young People and Neonates,, a matron (paediatrics and neonates), a care group manager for acute paediatrics and a care group manager for community paediatrics. There was a professional lead for health visiting and a professional lead for school nursing..
- The trust had introduced a new senior nurse role of divisional director of nursing for children, young people and neonates in December 2016. This post spanned across acute and community CYP services.
- Staff told us their immediate line managers were visible and approachable and that they would receive feedback if they raised queries or concerns.
- Staff told us that although they knew who they were and would feel comfortable with approaching board members, they were not visible and had not been out to community teams to speak with staff or see the service.
- There had not been a service lead for physiotherapy and occupational therapy for several months due to long-term sick leave. As a result of this leadership gap some staff told us they felt that the service had seemed overlooked by the trust. An acting lead had been in place for three weeks prior to the inspection and staff were hoping there would be improvements with communications as a result.
- Staff working within the school nursing team told us their managers had worked hard to drive improvements with the service and were very well respected by everyone we spoke with.
- Two staff members had been nominated for awards at external events as managers recognised the positive outcomes of work they had led.

Service vision and strategy

- Staff were aware of the trust vision and values of their service and these were displayed in the centres we visited during the inspection.
- There was no specific strategy in place for the community CYP service however it was part of the trust wide strategy and also that in partnerships with stakeholders. Staff we spoke with told us they were aware of their role with the future of each service and that they were kept well informed of upcoming changes that would affect them.
- The community children's nursing team had been informed that the base that they worked from would be relocated to the acute hospital. Staff told us they had not felt fully part of consultations and decision making with this plan. They told us they felt that it had been led

by senior managers without consideration to how their work would be impacted. Senior managers told us and we saw evidence that a group consultation had been held and that one to one meetings took place after this.

Governance, risk management and quality measurement

- There were systems in place to enable managers to identify and respond to issues affecting the service. All staff we spoke with told us they knew the process for raising concerns and would receive feedback when appropriate.
- A divisional safety huddle was held weekly where incidents and their outcomes, complaints tracking and update to risk registers were discussed.
- We saw minutes from monthly speciality quality team meetings attended by service leads, clinical leads, and key medical and nursing staff members from all CYP services and saw that incidents and learning was reviewed and shared across the service.
- Staff we spoke with told us they were aware that their service was listened to at a senior management level and received communication about current issues.
- We reviewed the service risk register and saw that there were 11 risks identified including the increasing demand on the service to manage safeguarding concerns, lone working and potential breach of confidentiality with the transportation of patient records. The risk register had review dates, control measures, actions and risks were rag rated.
- We had concerns about the management of the activities staff within the CCN team told us had taken place with children and young people in their care. It was clear that staff within the service did not have a full understanding of professional boundaries and risk management. When we returned for the unannounced inspection, we saw that some information had been provided about professional boundaries and that staff had signed to say they agreed with the terms.

Culture within this service

- All staff we spoke with told us they were proud to work for the trust, that there was an open and honest culture with patient's care being the focus for everyone. Staff said the teams were supportive and they enjoyed their jobs.
- Staff told us they felt emotionally well supported by their managers and senior leads and would be comfortable in reporting concerns to senior staff members. All staff said they felt valued by their own teams however, some told us they did not feel valued by the wider trust.
- There was an open culture about incident reporting across community CYP services. We saw that near miss situations were reported and discussed with learning opportunities shared appropriately.
- Nurses working in CYP community services had had been awarded the title of 'Queen's nurse' for above and beyond call of duty work completed. A number of health visitors were fellows of the institute of health visiting which recognises staff delivering excellence in practice.

Public engagement

- A charity group, which included current and previous parents and carers of children who used the CYP service, was in place and funding had been used for equipment across the therapies services.
- A board was displayed at the child development centre with paper available for parents and carers to provide immediate feedback about CYP services.
- An autism working group comprising of staff from the trust, local authority, other local services and parents and carers had devised an action plan to improve services for children and young people. This group met three times per year to review the actions completed and the ongoing progress. Parents and carers on the group fed back to their communities and also received input this way to take issues with services or suggestions to the group.
- The school nursing service used social media and their website to engage young people with the service. A confidential text messaging service called "chat health" was also used to assist this patient group.
- There was an accredited programme in place for young people to become school nurse champions and support their peers with information about access to school nurses. The school nursing service trained young people through the school nurse champions programme to work with their peers to consult on development and improvement of services. Young people shared findings with senior leaders and commissioners to inform service development and changes had been implemented as a result. We saw posters and information displayed for patients and parents and carers in clinic rooms and centres.

Good

Are services well-led?

Staff engagement

- Two staff members employed in the transition team had been previous service users who had completed apprenticeships. Staff told us they were able to engage well with patients and had made significant positive improvements because of their insight.
- The health visiting team received a weekly information bulletin called "treat of the week" issued by the team leader and contained information including performance against key performance indicators.
- The health visiting team held an exercise in their monthly team meetings to give staff the opportunity to share any issues.
- School nursing staff told us they participated in team building sessions such as a pub quiz.

Innovation, improvement and sustainability

- The CYP service had rolled out a minor illnesses app for 0-5 year olds to assist parents and carers with diagnosing and treating or signposting to appropriate services.
- The 'First Steps' programme was an initiative developed by the health visiting service to support parents through the transition into parenthood. This was supported and adopted by the institute of health visiting.
- The speech and language therapy team had won the NHS England Allied Health Professional Award for associate of the year 2017. This was specifically for the 'little learners' group initiative which involved 90 children, their parents/carers and teaching assistants.
- Staff who had developed the 'little learners' sessions had been recognised for innovative working by their managers and were nominated for a trust award.
- The teenage pregnancy and school nursing service worked with a sexual health charity to develop an evidence informed sex and relationships education (SRE) toolkit to support the delivery in schools. School nurses delivered teacher training and class room teaching to establish a sustainable delivery approach to SRE.
- The teenage pregnancy service had developed a website called 'Easy SRE', a toolkit of resources to support sex and relationships education.
- A community paediatric referral panel was held weekly for multi-disciplinary discussion and decision making as well as review and co-ordination of assessment and treatment.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. Care and treatment must be provided in a safe way for service users. The registered person must ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. The registered person must assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. Blind cords were not secured in all of the rooms at the child development centre. Regulations 12(1), 12(2)(e), 12(2)(h).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users must be treated with dignity and respect. The registered person must ensure the privacy of the service user. The community children's nursing team took patients' records home when they were not returning to the office. We were not assured of the confidentiality or security of records. Regulations 10(1), 10(2)(a).