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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- Five out of 14 parents and carers we spoke with during the inspection site visit, and 5 people who contacted CQC independently during the inspection process expressed concerns about difficulties getting in touch with staff, and long waits to be seen leaving them feeling unsupported to manage health concerns about their babies/children.
- Despite significant improvements in safeguarding and governance systems at the service, as required in the warning notices issued in June 2023, further work was needed to fully address the breaches of regulation and to ensure that improvements were embedded and sustained. We found some on-going concerns with the management and oversight of children and families transferring into the service, and those with safeguarding concerns. This meant that children and families who were potentially vulnerable or high risk might not be identified or supported in a timely manner.
- We found that a small number of children and family safeguarding concerns were not managed appropriately when children transferred in and out of the service. Some families were not being seen and reviewed in accordance with the timescales expected in the provider's own policy, placing them at risk of avoidable harm.
- Despite improvements, the service leaders had not ensured that the assurance systems in place were robust enough to monitor, identify and address risks that impacted on patient safety, and staffing decisions did not impact negatively on families within the local population.
- Despite a requirement made at the inspection in November 2022, between April and June 2023, the service had only been able to provide a 6 to 8 week review for 21% of infants. The 6 to 8 week check is a vital part of the Healthy Child Programme and missing this might mean that families' needs would not be identified, including any mental health needs. Over this 3 month period, only 28% of babies received a 12 month review, and 30% received a 2 to 2.5 year review by the age of 3 years.
- Following recent reductions in staffing just prior to the current inspection, the service was proposing a further reduced model particularly impacting on the universal pathway. If accepted this would include no psychosocial contact, reductions in breastfeeding support, continuing non-provision of 6 to 8-week visits for families unless they were identified as high risk, and virtual 1 year reviews for babies assessed as lower risk. This model had not been accepted by the service commissioners and staff we spoke with were concerned about the ramifications of this on vulnerable families in the borough.
- Whilst client records had improved as required at the inspection in November 2022, there were some gaps in the information recorded in some of the cases we reviewed.
- As required at the inspection in November 2022, the provider had worked hard to improve staff morale. However, following recent changes to the staffing of the service, staff reported low levels of morale and concerns about their job security.
- There had been improvements in provision of supervision to staff members as required at the inspection in November 2022, although further work was need to increase attendance at clinical supervision sessions.
- Most parents and carers we spoke with were not clear about how to complain and give feedback to the service.

However:

- As required at the inspection in November 2022, staff had received mandatory training in key skills, and understood how to protect children and young people from abuse. The service controlled infection risk well, and the service was notifying CQC of incidents as appropriate. The service managed safety incidents well and learned lessons from them.
- As required at the inspection in November 2022 staff had undertaken level 3 safeguarding training for adults and children and were receiving regular safeguarding supervision.

Summary of findings

- The service had appointed a specialist education needs and disability (SEND) lead and was working to improve the offer for children in the area. Staff had completed training in Autism and SEND.
- When staff did see families, staff treated children and young people with compassion and kindness. Parents and carers spoke highly of individual staff who had supported them. Staff advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

As a result of the concerns we identified we issued the provider with 2 Warning Notices 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 24 November 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	Inadequate 	see section above

Summary of findings

Contents

Summary of this inspection

Background to Solutions 4 Health - Barnet

We undertook this unannounced, comprehensive inspection of Solutions 4 Health- Barnet to follow up on the actions taken by the service to address the breaches of regulation as a result of the section 29 warning notices served following our focused inspection in April 2023.

At the April 2023 inspection, we found that there were insufficiently robust safeguarding systems and processes in place to ensure children, young people and their families were appropriately assessed, reviewed and identified risks were managed in a timely manner. We also found that the service did not have a robust governance and assurance systems in place to oversee and monitor the quality and safety of care.

The warning notices required the provider to make improvements by 24 November 2023.

Solutions 4 Health - Barnet provides an integrated health visiting and school nursing service that supports children and young people aged 0 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 Limited. 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 0 to 5. 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, 6 to 8 week reviews, 1 year development reviews, and 2 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 5 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. 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. At the inspection in November 2022, we rated the service as requires improvement overall. Safe was rated as inadequate, effective, responsive and well-led as requires improvement, caring was rated as good.

What people who use the service say

We spoke with 14 families that had used the service and 11 of these famlies reported wholly positive experiences from direct communication with staff. Families told us that the health professional they spoke with provided advice when they needed it and made them feel comfortable.

Eight parents/carers told us of their difficulties getting appointments when they were worried about their child's development. Three parents/carers said that if they did not contact health visitors, they would not have any contact from them including for mandated checks.

How we carried out this inspection

On the first day 1 inspector and 3 specialist advisors attended the service, and on the second day the same inspector and 2 specialist advisors attended. Two separate inspectors carried out telephone calls to staff and parents/carers remotely. In total, the inspection team consisted of 3 inspectors and 3 specialist advisors with clinical backgrounds in safeguarding, health visiting, and school nursing.

Summary of this inspection

During the inspection we:

• spoke with 14 families who had used the service

• spoke with 26 members of staff including public health nursing managers, team leads, health visitors, school nurses, nursery nurses, and administrators

• spoke with 5 senior leaders of the service including the registered manager

• reviewed electronic records detailing the care and treatment of 21 patients

• attended one clinic at a children's centre

• attended a multi disciplinary meeting, and a duty team meeting

• looked at a range of policies, procedures and documents related to the service

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must continue to improve safeguarding systems and processes to ensure children, young people and their families are appropriately assessed and reviewed and identified risks are managed in a timely manner, including when they move into or out of the borough in line with the provider's policy Regulation 13 (1)(2)(3)
- The provider must ensure that the service's governance and assurance systems and risk register are further strengthened to oversee and monitor the quality and safety of care. Regulation 17 (1)(2)
- The provider must ensure that decisions about service staffing do not impact on the safety of services to families within the local area. Regulation 18 (1)
- The provider must improve performance in completing checks for the mandated milestones outlined in the Healthy Child Programme so that children at risk of deterioration are escalated appropriately. Regulation 12 (1)(2)(a)(b)
- The provider must ensure that staff provide sufficient and timely support and information to parents and carers enabling them to make decisions about their children's care and treatment. Regulation 9 (1)(3)(a)(b)(c)(d)
- The provider must work to address concerns about staff morale following recent changes to the staffing of the service. Regulation 18 (2)(a)
- The provider must ensure that clinical records are up to date with important information and include information about follow up action planned and completed. Regulation 12 (1) (2)(a)(b)

Action the service SHOULD take to improve:

Summary of this inspection

- The provider should ensure that all parents and carers are given clear information about how to complain to and give feedback about the service.
- The provider should work further to improve levels of attendance at staff clinical supervision sessions.

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	Requires Improvement	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate	Inadequate

Community health services for children, young people and families

Inadequate

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

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training was comprehensive and met the needs of children, young people and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

At the previous comprehensive inspection in November 2022, we found that staff were not up to date with their required mandatory training. This had improved significantly to 92% overall compliance by the time of the current inspection, although there were some areas still needing improvement.

The provider had arranged for staff to have protected time to complete any outstanding mandatory training. There were improvements in infection prevention and control training (from 42% at the time of the last inspection) to 87%, and in mental health awareness from 34% previously to 92%.

Overall training in most mandatory areas was above the provider's target of 85%. There were some training modules that were below the provider's target for example freedom to speak up training at 74% for all staff and 56% in freedom to speak up training for leaders.

Staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. At the time of the inspection 96% of staff were trained, there were also plans to roll out this training to administrative staff.

Safeguarding

Community health services for children, young people and families

Inadequate

The service had made significant improvements to safeguarding systems, although records were not always kept up to date, and there remained concerns about families moving into the area being seen promptly. Staff understood how to protect children, young people and their families from abuse. The service worked with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Following the most recent focused inspection in April 2023 we served a warning notice to the provider due to ongoing concerns that safeguarding systems and processes in place were insufficient to ensure children, young people and their families were appropriately assessed and reviewed and identified risks were managed.

During this inspection we reviewed 9 patient records for families and children who had transferred into the service. We found that in 3 of the 9 records, there was no evidence that the children and their families had received the right level of care and support to ensure they were protected from abuse and improper treatment. We also reviewed 5 safeguarding records for the service, of which 1 record did not provide assurance that the appropriate monitoring had taken place. Some families were not being seen and reviewed in accordance with the timescales expected in the provider's own policy, placing them at risk of avoidable harm.

The provider's policy stated that any child transferring into the service should be allocated to a health visitor within 1 to 3 working days, and all children and their families must receive a risk assessment to determine their level of support within 3 to 7 days. Some children and families were not being monitored and seen in a timely way which impacted on the level of care and support they received. Systems that had been developed and put in place to monitor the service's performance in managing families moving into the borough and those with safeguarding concerns, did not identify the concerns we found during the inspection.

A baby under 1 year old who had transferred into the borough in July 2023, was not given an appointment to be seen until 20 days later, which the family did not attend. The family contacted the service a month after this to ask about having a health visitor appointment. Another patient referred into the service in June 2023 via the Multi Agency Safeguarding Hub, having transferred into the borough, was not assessed until 14 days later, and not allocated a health visitor until 15 days after referral. Although later safeguarding concerns were followed up by the service with social services, at the time of the inspection, there was no known address for this patient. A 15-year-old child on a child protection plan transferred to the borough in April 2023. The patient was not allocated a school nurse and did not have a transfer in or any other review from the service, although he was attending a Barnet school. At the time of the inspection the whereabouts of this child were unknown and we found the provider had not taken sufficient action to determine the child's whereabouts until we escalated this to staff at the service. Following this escalation, the service established the child had moved out of the borough. A baby born in April 2023, had no concerns, although they lived with a sibling aged 18 months for whom records indicated concerns about domestic abuse. We escalated this case to staff at the service. In none of these cases was there any evidence of harm to the babies/children involved. However, these cases indicated that families were not allocated and seen in accordance with the provider’s own policy.

We found significant improvement in staff training on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There was also an improvement in the provision of safeguarding supervision provided to staff. Specialist health visitors with a caseload including a high number of cases assessed as having high needs were offered safeguarding supervision fortnightly. Nursery nurses, the breastfeeding and healthy weight teams received group safeguarding supervision every

8 weeks. The provider had also introduced 'catch up and reflect' groups for staff who had not been able to attend clinical supervision. The provider had added a new supervision template to the patient record for all safeguarding supervision and safeguarding concerns to be recorded. Staff told us that they were able to choose which cases to bring to supervision. Of the 5 safeguarding cases we reviewed, 1 had been taken to safeguarding supervision.

At the time of the inspection there were 258 children on a child protection plan within the borough of Barnet. To ensure that safeguarding cases received appropriate attention, the service had allocated 3.6 whole time equivalent (WTE) staff to have a 'vulnerable case load' to cover the cases with the highest level of need. There was also an increase of 1 WTE safeguarding advisor added to the team. A new safeguarding leadership team had been established including a director of safeguarding, and a head of safeguarding for the company who were in the process of reviewing the company's policies and procedures. There was an organisation wide safeguarding leads meeting, reporting to the quality and safeguarding committee, which provided a quarterly report to the integrated care board and local safeguarding partnership. Managers were clear that reductions in overall staffing would not impact on safeguarding practice, as safeguarding human resources had been protected.

The service attended safeguarding conferences, though due to staffing shortages, had continued to attend these remotely after such conferences had recently returned to taking place in person. This arrangement had been agreed in advance with conference chairs.

Cleanliness, infection control and hygiene

The service controlled infection risk well. 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.

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, were bare below the elbows, 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 Underhill Children's Centre. Staff ensured that they allowed enough time between each family so that they could thoroughly clean the clinical areas and toys. As recommended at the inspection in November 2022, staff were recording when they cleaned individual toys, and we observed this in practice.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

All staff had a personal panic alarm that they could wear whilst working alone in the community. The service also had a 'buddy' system which meant staff informed colleagues of their whereabouts at any given time. The service had a lone working policy in place to guide staff when working alone.

Community health services for children, young people and families

Inadequate

Staff carried out safety checks on specialist equipment, and used suitable facilities to meet the needs of children and young people's families. The service had enough suitable equipment to help them to safely care for children and young people.

Assessing and responding to patient risk

Staff completed risk assessments for each child and young person, although these were not always kept updated. Staff were not able to offer all aspects of the Healthy Child Programme. This meant there was an increased risk some families with unknown health risks or safeguarding concerns would not be identified.

Since the provider took over the 0 to 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 was 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, 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.

The service was only providing antenatal visits to mothers assessed to be at high risk (19 mothers received an antenatal visit between April and June 2023).

Following the previous inspection in April 2023, staff were completing new birth visits (NBV) in person and had ceased undertaking these virtually. The service was commissioned to deliver (universal) new birth visits within 30 days. They completed 44% of new birth visits within 14 days, and 92% of new birth visits between 14 and 21 days between April and June 2023.

The service only provided a 6 to 8 week reviews for 22% of infants during this time period. The 6 to 8 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. Over this 3 month period, 28% of baby's received a 12 month review, and 30% received a 2 to 2.5 year review by the age of 3 years. This left approximately two thirds of babies in the borough without these mandated checks which might impact on their speech and language, social and emotional well-being and exacerbate inequalities.

Staff used a tool to identify children or young people at risk of deterioration and escalate them appropriately. However, due to the low compliance with the milestone reviews, there was a risk that significant changes might be missed.

There were new protocols in place for all babies/children who transferred into the borough, including triage by a duty health visitor, and daily triage meetings to ensure that they were followed up.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. A recent audit of 125 families who moved out of the borough indicated that in 93% of cases, staff had a verbal handover with the equivalent team at their new borough.

Staffing

Community health services for children, young people and families

Inadequate

The service had vacancies for health visitors and school nurses and had provided cover with agency staff. However, just before our inspection, the service had reduced the use of agency staff. Staff told us they believed this would have a negative impact on service delivery.

The service had a high vacancy rate. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. Team leaders assessed the size of their team caseloads regularly and, where possible, helped staff to manage the size of their caseloads. Although 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.

When Solutions 4 Health - Barnet took over the service in April 2022, the staffing establishment was 35.2 health visitors and 6.1 school nurses, with an overall total workforce of 67.2 whole time equivalent (WTE) staff. In July 2023 there were 42.7 health visitors, and 32 school nurses, however of these 26.5 were agency health visitors, and 5 were agency school nurses due to vacancies (with an overall workforce of 102.7 WTE). At the start of our inspection on Monday 11 September 2023 the staffing had reduced to 83.4 WTE (100 staff). This was a reduction of 19.3 WTE posts since July 2023, with 11.4 WTE staff reduced on Friday 8 September 2023. Management advised that this was based on their funding rather than the provider's calculation of the number of staff needed to provide a safe service.

This reduction in staffing was deemed necessary due to budgetary constraints, and the provider was in contact with the commissioners to discuss a safe way forward for the service to function. The impact of the staffing issues meant that teams had to prioritise children, young people and families that were at risk and vulnerable. Staff at the service were unsettled by the most recent staff reduction and expressed concerns about their job security, and the quality of service they would be able to provide to families. The duty team had been reduced from 6 to 5 health visitors. There were plans for team leaders to step in to take on complex health visiting cases.

The provider was working to address vacancies by recruitment adverts and incentives to attract new applicants and by employing agency staff. The provider had also implemented a skill mix model with a combination of clinical and non-clinical staff with different skills in order to deliver the required health checks.

Staff sickness rates in July were 2.8% and in August 2023 this had increased to 5.8%. Staff numbers on long term sickness had increased from 10 in July to 19 in August. NHS average sickness rates for July and August 2023 were 4.8% and 4.9% respectively. In July 2023 12 staff left the service (5 resigned) and in August 2023 5 staff left the service (1 resigned).

The provider had previously also agreed with commissioners that they would not be able to deliver some 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 6 to 8 week mandated check. Following the inspection the provider told us that they were continuing to work and develop staff continuity plans.

At the time of the inspection, the model proposed by the service, which had not been agreed with commissioners included reductions in targets for mandatory checks, psychosocial support, and breastfeeding support. For families moving into the borough, the plan was for home contact to be offered only to infants under the age of 1, or on a statutory plan. Following the inspection the service advised that no psychosocial meetings had been missed, and there had been an increase in breastfeeding support at clinics.

Shortly after the inspection the provider informed us that, following negotiations with the local commissioners, they had secured Agenda For Change uplift funds, which would be distributed to staff.

Community health services for children, young people and families

Inadequate

Records

Staff kept records of children and young people's care and treatment. Records were clear, stored securely, and easily available to all staff providing care. However, there were some gaps in records which meant that some records were not fully up to date.

At the previous comprehensive inspection in November 2022, we required that clinical records be kept up to date with important information and include the rationale for clinical decision making.

The provider had undertaken a number of quantitative, and qualitative audits which involved looking at 651 records for families on the universal pathway, 290 records of families moving in, and 125 families moving out of the borough.

The quality of records had improved since the previous inspection. Records were stored securely and were easily available to all staff providing care, but there were some gaps in the information recorded in some cases as noted above.

Medicines

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

The Underhill 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

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Safety incidents were reported and investigated appropriately, and the service had put in systems to ensure that learning from incidents was shared with the team and implemented robustly. Following learning from a serious incident in April 2022, the service had put in place a more robust transfer in and out pathway. Other learning from serious incidents included the use of scheduled tasks on the system, introducing audits of health reviews, staff undertaking training in neglect training, and weight and growth training. Clinical supervision groups, and staff forums as well as 7-minute briefings, were used to ensure learning from cases was shared.

Staff understood the term duty of candour by which providers of healthcare services must be open and honest with patients and other 'relevant persons' when things go wrong with care and treatment. Staff were able to provide examples of when they would offer support and apologise.

Staff confirmed that managers debriefed and supported them after any serious incident and took action in response to patient safety alerts.

Community health services for children, young people and families

Inadequate

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. However, the service was not able to deliver all aspects of the national Healthy Child Programme (HCP) on the universal pathway due to high demand and insufficient staffing.

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 were not able to deliver all aspects of the national Healthy Child Programme (HCP) on the universal pathway. This was largely due to the high demand on the service and staffing shortages. The service therefore focused their resources on families identified as vulnerable or requiring enhanced support. There were clear systems in place to follow if families did not respond to attempted contacts, and if specialist support was required such as audiology or speech therapy.

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. 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, however they were looking to reduce input into this programme due to staffing issues. Following the inspection the service advised that no psychosocial meetings had been missed. The school nursing service was implementing The Lancaster Model, an evidence-based online questionnaire designed to identify early health and wellbeing needs, allowing the team to respond quickly and provide support. They noted that they were reviewing the use of this model, to ensure that it was appropriate for the local population at this time.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. At handover meetings, staff routinely referred to the emotional needs of children, young people and their families. At the time of the inspection the infant feeding team had 5 team members and responded to parent requests.

We found evidence of prompt case allocation and assessment in the majority of cases. However, we found three cases where records did not show evidence of the child being seen or recent follow up.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements but their ability to achieve good outcomes for children and young people was limited by staff availability.

Community health services for children, young people and families

Inadequate

The service was monitoring 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 had undertaken a number of recent clinical audits.

Managers and staff carried out a programme of audits to check improvement over time. They used information from the audits to improve care and treatment. Most recently audits had been conducted for 290 families moving into the borough, 125 families moving out of the borough, and 651 universal cases. Learning points included ensuring that risk levels were recorded, and all records were updated with the latest action plans. There had not yet been an audit for children aged 5-19, but some 'dip' sampling had been carried out to ensure that risk assessments and planned actions were recorded and kept up to date.

The service was able to check on progress of the action plans using a management tool. The tool was to ensure that all actions had clearly recorded responsible individuals and clear timescales.

At the previous comprehensive inspection in November 2022, we required the service to improve performance in completing checks for the mandated milestones outlined in the Healthy Child Programme. However, performance in several areas was still poor. Managers advised that performance was adversely affected by additional responsibilities placed on the service during this time period by commissioners, including offering vitamins to refugee families in temporary accommodation, and auditing of backlogs. These additional responsibilities were not part of the original contract.

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), 6 to 8 week reviews, 1 year and 2 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, this was due to staffing issues. Pregnant women on the universal pathway were monitored via the local midwifery service.

Between April to June 2023 the service completed 44% of new birth visits within 14 days, and 92% of new birth visits between 14 and 21 days. They only provided a 6 to 8 week reviews for 22% of infants during this time period, 28% of infants received a 12 month review, and 30% received a 2 to 2.5 year review by the age of 3 years.

The service had commissioned an ongoing independent evaluation of the virtual offer provided to families (such as information provided and video call appointments).

A new reduced model of provision of the HCP was proposed by the service in line with reduced staffing from the day of the inspection.

At the previous comprehensive inspection in November 2022, we found that the service needed to further develop and implement their specialist education needs and disability (SEND) offer. At the current inspection we found that staff had received further training in Autism and SEND, and further face to face training was planned. 85% of staff had completed training in SEND and 81% of staff were up to date with Oliver McGowan learning disability and autism training.

Competent staff

Community health services for children, young people and families

Inadequate

The service made sure staff were competent for their roles. Managers appraised staff members' work performance and had increased the frequency of supervision meetings with staff to provide support and development, although further work was needed to increase attendance at clinical supervision sessions.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families.

At the previous comprehensive inspection in November 2022, we found that clinical staff did not always receive regular clinical supervision and that this was not being monitored. At this inspection, staff we spoke with said that they had clinical supervision and safeguarding supervision available to them. Managers had put in place regular clinical supervision sessions for staff in each of the teams, including group and individual sessions. Clinical supervision was being provided every 6 to 8 weeks, alongside group supervision every 2 weeks, and team meetings monthly, however the overall team compliance with supervision in July 2023 was 41%.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service was in the process of arranging staff appraisals for members of the staff team who had been in post for a year or more.

The provider had recruited into specialist roles and was involved in ongoing recruiting of staff to other vacant posts. Managers gave all new staff a full induction tailored to their role before they started work. The service required staff to complete competency-based assessments before they were able to work independently. Some newer staff said that with recent changes in staffing, it had been difficult to find a consistent staff member to act as a mentor or buddy.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They had recently provided additional training for staff in child weight management. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Some staff said that leadership training was available to them through the provider intranet.

Managers identified poor staff performance promptly and supported staff to improve. At the time of the inspection, no staff were being managed due to concerns about their performance. However, the majority of staff we spoke with said that they had concerns about staff morale and their own job security following recent staffing changes at the service.

Multidisciplinary working

Staff worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

All healthcare professionals responsible for delivering care worked together as a team to benefit children, young people and their families. Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care, these included team meetings, and a monthly 0 to19 staff forum with opportunities for staff training and sharing learning.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. For example, there were strong links with the local paediatric dysphagia team, speech and language therapists, special educational needs and disability, and perinatal mental health teams. Staff told us that there had been an improvement in communication with the local midwifery services, but there were still sometimes delays in receiving discharge summaries from the midwifery service when mothers were discharged from hospital.

Community health services for children, young people and families

Inadequate

The service had allocated a health visitor or team leader to each local GP practice so that they could access direct support.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives when possible, but this was limited by low performance in meeting mandated milestone contacts.

The service had relevant information promoting healthy lifestyles and support. Staff were not always 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. Plans to stop providing the 6 week check on the universal pathway would further limit this support.

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, and immunisations with the parents. The staff members completed the personal child health record (red book) accordance with the HCP. The service had a small oral health team in place that was responsible for teaching parents, 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.

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. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff knew how to support parents 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 90% a significant improvement following the previous comprehensive inspection. Managers had also provided a recent 7 minute briefing to staff on the subject of consent. Training in mental health awareness was at 93%.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. They made sure that children, young people and their families consented to treatment based on all the information available. Staff clearly recorded consent in the children and young people's records.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions.

Community health services for children, young people and families

Inadequate

Is the service caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, and took account of their individual needs. However, staffing pressures meant that they were not always able to provide the support needed by families with young children in the borough.

We observed interactions between staff and families to be friendly and supportive. Parents/carers we spoke with were very positive about staff, describing them as kind, flexible and respectful. They said that staff were very knowledgeable and experienced and provided helpful support. However, we also received some complaints from families before, during and after the inspection who described difficulties contacting the service and with concerns that they had not received the required checks for their child, or had appointments cancelled at short notice.

Staff were responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Parents and carers were very positive about the staff that they had worked with. Staff usually followed policy to keep care and treatment confidential. However, in one case a parent told us that they had an appointment in the same room as another family, so confidentiality was compromised.

Some parents/carers said that they were not clear what was the role of health visitors, and that they would have liked to have more support and information.

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 and religious needs. However, some families experienced insufficient support, due to long waits for appointments and follow up and this aligned with performance data received from the provider which showed the service was not meeting mandated targets.

Staff gave children, young people and their families help, emotional support and advice when they needed it.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. They described work they undertook with refugee families, and ethnic and cultural groups within the borough.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's wellbeing.

Community health services for children, young people and families

Inadequate

We spoke with 14 families that had used the 0 to19 service and they all reported positive experiences from direct communication with staff. Families told us that the health professional they spoke with provided advice when they needed it and made them feel comfortable. Eight parents/carers told us of their difficulties getting appointments when they were worried about their child's development.

Understanding and involvement of patients and those close to them

When they were able to see families, staff supported and involved children, young people, and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Parents/carers told us that staff talked with children, young people and their families in a way they could understand.

As recommended at the previous comprehensive inspection in November 2022, the service had developed further ways for children, young people, and their families to give feedback on the service and their treatment and staff supported them to do this. The service had created electronic feedback forms that were being sent out to families after their appointments. The results of these surveys were now being recorded on the electronic system, and the service was able to share some of these with us. Most of the feedback was very positive about the service. From January to March 2023 13 feedback forms were returned with 62% of these being positive, 35 responses were received from April to June 2023 of which 89% were positive, 46 responses were received from July to September of which 85% were positive.

When staff saw children, young people and their families, they supported them to make informed decisions about their care. Parents/carers described helpful information provided to them. However, a significant number of parents/carers described a lack of support and information from staff due to long waits for appointments to be seen.

Is the service responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Service delivery to meet the needs of local people

The service had been unable to provide all nationally mandated checks and support to all families in the communities they served. Following reduced staffing, managers were planning for a service that provided care in a way that met the needs of the most vulnerable families identified.

Service leads met regularly with commissioners to discuss performance targets and improvements they needed to make. However, they had been unable to meet performance targets for mandated checks on babies and young children as part of the Healthy Child Programme. At the time of the inspection, the service had reduced staffing to a level at which they were further unable to provide all mandated health checks for families of young children. See Safe section, on Assessing and responding to patient risk, for more details.

Community health services for children, young people and families

Inadequate

The service worked with others in the wider system and local organisations to provide updates about the service and to plan care moving forward. Staff had worked to address concerns from local GPs who had raised concerns that parents and carers were unable to contact the service directly by telephone. At the time of the inspection, there had been an improvement in this area with a reduction in complaints about difficulties getting through to the service.

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. There were approximately 100 new births per week within the borough, of which about 10 included safeguarding considerations. 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. There were 66 primary schools, and 30 secondary schools within the borough. Occasional clinics could be arranged at weekends when needed.

At the previous comprehensive inspection in November 2022, we recommended that communication with local midwifery services should be improved. Staff reported that there had been an improvement in this area, and work was being undertaken to ensure that mothers discharged from hospital received their discharge summaries promptly from the midwives to provide to the health visiting service. However, there was further work needed to ensure that this change in relationship was fully embedded by both the midwifery teams and service.

Administrative staff contacted families to book health reviews and new birth appointments, gave advice on registering babies, and could refer to a health visitor for a call back in needed. At the time of the inspection, they were contacting families who had booked appointments with staff no longer working for the service, to rebook or postpone appointments. They sent out welcome packs to families who had moved into the borough including useful information about services. The service was planning 2 regular clinics to be held in each of the 3 areas into which the borough was divided. No drop-in clinics were provided in line with the commissioners stipulations.

Managers ensured that children, young people, and their families who did not attend appointments were contacted. The service had been using a small, adapted bus so that health visitor clinics could be delivered to children and families in the community. The service had parked the bus at various refugee centres, designated hotels, and other popular venues across Barnet as a way of engaging more families. The bus included some clinical equipment such as baby weighing scales. The service had involved local schools in the design of the bus and ran a competition for them to enter, with the winner selected for the branding of the bus. Over 3 weeks in June 2023 the 'Wheels on the bus' had provided a service to 150 families. The service was also sponsoring a local fathers' football team to improve engagement with fathers. Unfortunately, due to budgetary constraints, at the time of the inspection, the service had ceased using the 'Wheels on the bus.'

Meeting people's individual needs

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

The service had information leaflets available in languages spoken by the children, young people, their families, and local community. As recommended at the previous comprehensive inspection in November 2022, the service had made provisions to ensure that parents and carers were able to access information leaflets in a range of languages. One parent/carer we spoke with said that they had not been offered a translation and this would have been helpful. Managers made sure staff, children, young people, and their families could get help from interpreters or signers when needed.

Community health services for children, young people and families

Inadequate

At the previous inspection we also recommended that the service should continue to ensure that the specialist education needs and disability (SEND) offer was developed and implemented. By the time of the current inspection the service had recruited a SEND lead for the team, who was also able to undertake diagnosis of autism. They had ensured that the staff team received training in supporting children and adults with learning disabilities, autism and other specialist education needs. The service had plans to develop their specialist education needs and disability (SEND) offer further.

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 5. The application used artificial intelligence and could be used in conjunction with support from health visiting services. Solutions 4 Health – Barnet had embedded the use of the digital application into clinical practice and encouraged families to utilise it. The application provided 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 was useful and informative.

Staff noted that some religious and new schools within the borough did not want to have a school nursing service provided. They also noted that the healthy weight team had forged good relationships with schools, and also met with the youth justice team to ensure that support was provided within youth offending facilities.

Access and flow

Families told us that they could not always access the service when they needed it and often had to wait several weeks to be seen which they found stressful. Some parents/carers who contacted us directly indicated that their children had not been seen at all within their first 2 years.

The service was unable to offer all the mandated contacts that are set out in the Healthy Child Programme, and further proposals would further reduce the number of contacts in future. This was largely due to a lack of staffing and high demand on the service. See Safe section, on Assessing and responding to patient risk, for more details. Following recent reductions in staffing, the service had taken the decision to focus 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.

Prior to the inspection, the CQC received several 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. We also received whistleblowing concerns from staff before and after the current inspection, with concerns that they were unable to meet the local families' needs safely.

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 sent out text message reminders to families to encourage them to book in their next reviews. The service had improved procedures for managing children moving in and out of the area. Due to the service stopping 11 agency health visitors' employment shortly before the inspection, a significant number of previously made appointments for new birth visits and health checks had to be cancelled and rearranged during the time of the inspection.

Learning from complaints and concerns

Community health services for children, young people and families

Inadequate

Processes for people to give feedback and raise concerns about care received had been improved. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people, and their families in the investigation of their complaint. Several parents/carers contacted the CQC directly to express their concerns about the service.

People were able to give feedback and raise concerns about care received. The service had a system in place to manage complaints. Complaints received between October 2022 and March 2023 (12 in all) largely related to staff not answering telephone calls, missed visits, and long waits to be seen. Managers shared learning from complaints investigations with the staff team. Staff were aware of and could give examples of the learning from recent complaints. They noted that to address concerns with making contact with them, the service had arranged additional administrative support in answering calls promptly.

Most parents and carers we spoke with were not clear about how to complain and give feedback to the service. Most told us that they did not need to complain, however, prior to and following the inspection we received a number of complaints directly to CQC, indicating that some people were not satisfied with the service's complaints procedure.

Service leads had improved how they gathered and monitored informal feedback from service users by sending out electronic questionnaires after each appointment.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

The service and commissioners had not been able to reach an agreement as to the level of service they could provider to children and families because the commissioners considered delivery models proposed by the service to be unacceptable. This meant although senior leaders at the service understood the priorities and issues the service faced, they were unable to provide a safe and responsive service to families at the time of the inspection. This was impacting on staff morale.

Prior to our inspection in April 2023, there had been some instability in the leadership of the service due to staff changes. Since then, there had been a strengthening of the leadership structure, with the new head of service now embedded within the service, and three public health nursing leads for the health visiting service.

However, prior to and following the current inspection we received whistleblowing concerns from staff members with regard to delays in providing new birth visits and other checks, staff sickness and stress, lack of clinics, and insufficient handover with the agency staff who left employment shortly before the inspection.

Leaders were visible and approachable in the service and supported staff to develop their skills and take on more senior roles.

Community health services for children, young people and families

Inadequate

Since the previous inspections in November 2022 and April 2023, the service had employed an external safeguarding consultant to support the management of safeguarding. This made significant improvements to the management of safeguarding cases. Staff told us that there had been many improvements to the service since the previous comprehensive inspection in November 2022, and the focused inspection in April 2023. They reported that there had been an increase in morale, involvement and consultation in the service development, improved training, additional staff, and a culture where most staff felt able to speak up without fear of victimisation. However, following on from the leadership decision to reduce agency staffing just prior to the current inspection, staff described a significant drop in morale, uncertainty, and concerns about the service they would now be able to provide. The provider reported supporting staff during this period by holding regular meetings to ensure their voices were heard, working with senior staff to develop a business continuity plan, raising the profile of the 'Speak Up Guardian,' and securing the NHS Agenda for Change uplift.

Vision and Strategy

The service had a vision for what it wanted to achieve but also had a strategy for managing the service within existing funding constraints, which focused on the sustainability of services.

The service had created an operational model to be negotiated with commissioners, but this had not been agreed at the time of the inspection. Staff were unclear about how they should be working at the time of the inspection and expressed concerns about the limitation of the model in providing a safe service for children and families within the borough.

Culture

Most staff said that they had felt respected, supported, and valued in recent months, but that this had changed just before the inspection, when agency staffing was cut significantly, leading to uncertainty and a drop in morale. Staff focused on the needs of patients receiving care and promoted equality and diversity in their daily work. The service had systems in place to provide opportunities for career development.

At the previous comprehensive inspection in November 2022, we recommended that the service should continue to ensure that staff morale was improved across the service. Staff we spoke with at the time of the inspection acknowledged that morale had improved in recent months, with changes in management and a clear focus on improving the service to families in the borough. They noted that staff had been encouraged to take on more responsibilities, and there was a more positive atmosphere within the service. However, following the cuts to agency staffing on the Friday before the inspection, they expressed significant concerns about their job security, and concerns about how they would be able to meet service users' needs safely.

The service had a Freedom to Speak Up Guardian, but 4 staff members said that they did not feel confident to raise concerns about the service directly. Whistleblowing concerns raised directly to CQC were submitted anonymously. Staff training was provided in the freedom to speak up guardian role, with 74% of staff completing the basic level, and 56% of leaders completing the training level for leaders.

The service promoted equality and diversity in its daily work. Staff we spoke with gave examples of when they had been sensitive to a family's cultural and religious needs. Staff compliance with mandatory equality and diversity training was at 93%.

The service encouraged staff to use a wellbeing application to support them in having a work life balance.

Community health services for children, young people and families

Inadequate

Governance

Leaders had improved governance processes, although these still needed to be embedded. There were still some safeguarding issues which were not being picked up by monitoring processes. Performance with some aspects of the Health Child Programme (HCP) was significantly lower than expected. Staff at all levels had been clear about their roles and accountabilities, although there was some confusion following recent staffing changes. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

At the most recent focused inspection in April 2023, we served a warning notice with regard to the provider not having sufficient oversight to monitor, provide assurance and improve the quality and safety of care to children and families using the service.

By the time of the current inspection, leaders had strengthened governance processes adding further assurance systems to monitor families moving into and out of the borough, safeguarding cases, and ensuring that staff had access to safeguarding supervision. There remained areas for improvement, but performance had improved significantly. The service had arranged a number of audits to check on universal families, as well as those with safeguarding needs, and those moving into or out of the borough. There was a new quality and development lead in place for the service.

Improved safeguarding structures had been put in place with an executive safeguarding board, interim director of safeguarding (who would become permanent in December 2023), head of safeguarding, a quality and service improvement lead and named nurse, safeguarding advisors, and multi-agency safeguarding hub health practitioners.

Staff spoke highly of the support provided by the head of service. Until changes were announced as a result of agency staffing cuts, staff had been clear about their roles and accountabilities. They had regular opportunities to meet, discuss and learn from the performance of the service. They attended a regular staff forum during which service leaders shared information about service performance, offered training opportunities, and discussed best practice. Other regular meetings held included monthly team meetings, allocations meetings, duty meetings, and band 7 nurse meetings.

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 which confirmed that service risks, challenges and performance were discussed.

However, service performance with some aspects of the HCP between April to June 2023 were significantly lower than expected and raised safety concerns for families in the borough. Staff only provided a 6 to 8 week review for 22% of infants during this time period. Lack of provision of the 6-8-week check for young babies, presented a risk that their full needs would not be identified, including any maternal mental health needs. Over this 3-month period, 28% of baby's received a 12 month review, and 30% received a 2 to 2.5 year review by the age of 3 years. These existing risks were not flagged on the service's risk register at the time of the inspection. Although the service maintained a risk register, this comprised information about individual risks but did not include information about risk to overall service delivery.

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. They had plans to cope with unexpected events but a request for further funding for the service to ensure that it operated safely was not agreed with commissioners.

Senior leaders had produced a risk register in response to the reduction in use of agency staff at the service. However, even with the mitigations put in place, these left a high level of risk for families in the borough. The provider's top risks included: current staffing capacity for both the health visiting and school nursing teams, stabilising the workforce, and addressing staff morale, increased costs, low staff morale, and increased pressure on and from external partners.

CQC were informed by senior operational managers at the time of the inspection that of the model proposed for future support with the new staffing numbers, which had not been agreed with commissioners included: no antenatal contact, no psychosocial meetings for the Maternal Early Childhood Sustained Home-visiting programme or CONI (care of next infant after death of previous child); no A&E follow up unless safeguarding concerns raised; reductions in breastfeeding support; 6 to8 week home visits only for those at high risk; virtual 1 year health reviews for babies assessed as lower risk; and 2 year health reviews for all (in person for those assessed as higher risk).

For families moving into the borough, the plan was for home contact to be offered only to infants under the age of 1, or on a statutory plan.

Recruitment of health visiting staff was a national problem, and leaders noted that the service was competing with neighbouring boroughs who had the funds to offer recruitment retention packages.

The service had put in place a workforce development plan. This included opportunities for leadership development, and a pilot with a local university to recruit 4 experienced public health nurses, and support for them to undertake a senior leader apprenticeship. They were also looking to work with higher education providers on a scheme for second year staff nurses to be offered a final placement at the service, with a mentor and the offer of a financial retainer if they remained working at the service after completing the course. They were looking at incorporating hybrid working, with some client contact undertaken virtually.

However, staff were very concerned about the cuts to the agency staff team. Staff had also been instructed that there was no more overtime budget. They noted that some staff worked very long hours, and were concerned about the increased pressures on them, with the reduction in staffing. Team leaders who had previously not held a caseload, were to be taking on complex cases to mitigate risks to families with high needs.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

At the previous comprehensive inspection in November 2022, we found that the provider was not notifying the Care Quality Commission of all incidents requiring notification, without delay. This had improved by the time of the current inspection, with notifications being made as appropriate.

The administration hub ran performance reports and shared them with service leads. The service was required to submit regular reports to the commissioners.

There were systems in place on the electronic records system to protect confidentiality of client's records. For example, if a staff member wanted to look at a record of a client who was out of area, the system requested the reason for this. If breaches in data protection were found, these were addressed promptly as appropriate.

Community health services for children, young people and families

Inadequate

Engagement

Leaders and staff actively engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, the impact of staffing reductions on all stakeholders had yet to be discussed outside of the service.

At the previous comprehensive inspection in November 2022, we recommended that the service should improve the ways in which families could give informal feedback, complaints, and compliments about their experience. This had improved by the time of the current inspection, with feedback forms being sent out after appointments, and feedback being collated.

The service had made contact with partner organisations such as local GPs practices and midwifery liaison and had also made contact with some local communities such as the Jewish community. The service had set up an outreach initiative called 'wheels on the bus'. The mobile bus unit had attended community venues and provided an opportunity for staff to engage with families and promote health and wellbeing. However, due to the staffing cuts, the bus was no longer in use.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and had participated in some research.

The service held regular staff forums with guest speakers invited, discussions on clinical practice and opportunities for group training. They had piloted a virtual duty team, who were available to speak to parents/carers about their concerns and undertake some of the mandated checks virtually (this was no longer being done for new birth visits). Independent evaluation was being carried out regarding the service's virtual offer, by a professor in child public health.

The 'wheels on the bus,' whilst no longer in use at the time of the inspection, had been a success in engaging with harder to reach families. The service encouraged families to use an artificial intelligence application called 'Ask Teddi' (in partnership with national charities) available at all times to provide useful information about immunisations, breast feeding. This was also available in different languages.

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 The provider must improve performance in completing checks for the mandated milestones outlined in the Healthy Child Programme so that children at risk of deterioration are escalated appropriately. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure that staff provide sufficient and timely support and information to parents and carers enabling them to make decisions about their children's care and treatment. Regulation 9 (1)(3)(a)(b)(c)(d)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must work to address concerns about staff morale following recent changes to the staffing of the service. Regulation 18 (2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

The provider must ensure that decisions about service staffing do not impact on the safety of services to families within the local area. Regulation 18 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that clinical records are up to date with important information and include information about follow up action planned and completed. Regulation 12 (1) (2)(a)(b)

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that the service's governance and assurance systems and risk register are further strengthened to oversee and monitor the quality and safety of care. Regulation 17 (1)(2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider must continue to improve safeguarding systems and processes to ensure children, young people and their families are appropriately assessed and reviewed and identified risks are managed in a timely manner, including when they move into or out of the borough in line with the provider's policy. Regulation 13 (1)(2)(3)