

Derbyshire Healthcare NHS Foundation Trust

RXM

Community health services for children, young people and families

Quality Report

Ashbourne House Trust HQ

Kingsway,

Derby

DE22 3LZ

Tel: 01332 623700

Website:

www.derbyshirehealthcareft.nhs.uk

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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)
RXM14	Trust HQ		




This report describes our judgement of the quality of care provided within this core service by Derbyshire Healthcare NHS Foundation 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 Derbyshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Derbyshire Healthcare NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

The service was well led locally, however staff reported that the executive team were not visible and there was a mixed knowledge of the trust's strategy and governance arrangements.

Medical staffing was not at establishment, the paediatricians were having difficulties finding suitably qualified staff to fill their vacancies.

Where there were long waiting lists there were strategies in place to minimise the effect this had on the children and young people.

Not all members of staff had completed mandatory training to comply with the trust target.

Safeguarding procedures were in place with clear lines of reporting. Staff were aware of these procedures and their responsibilities for safeguarding of children and young people. However not all staff had three monthly safeguarding supervision.

The Derbyshire Healthcare NHS Foundation Trust had systems in place for incident recording, investigating and monitoring. Lessons were learnt, when necessary, to prevent similar incidents from happening again.

The feedback from children, young people, their parents and carers was extremely positive at all the locations and programmes we visited. Staff were kind and caring; we observed excellent interactions between staff, children,

young people, and their parents or carers. Everyone we spoke with on the telephone, face to face and met in clinics were overwhelmingly positive about staff, they told us staff were kind, caring and listened to their concerns. Staff ensured people experienced compassionate care which promoted their dignity. Staff coordinated care for the whole family and were committed to helping meet people's emotional, social and welfare needs in addition to their health needs.

Services were located where people could access them, and offered a range of times to accommodate people's preferences. Overall, children, young people and families received timely community healthcare services. Services met their performance targets with very few exceptions.

The trust worked in partnership with other agencies such as neighbouring trusts, the local authority, education authority and voluntary organisations. We saw evidence that partnership working was routinely included in every aspect of their work. Staff were passionate about their role and they were continually looking how to improve services for children and young people.

The trust provided some unique services to children and young people. These included parent training programmes for Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

Summary of findings

Background to the service

The Derbyshire Healthcare NHS Foundation Trust provides a variety of community health services for children, young people and their families. This included health visiting, school nursing, learning disabilities team, looked after children, vulnerable children, community paediatricians, lighthouse, continence nurses, physiotherapy and occupational therapy.

The population served has a large number of families from ethnic minority groups. The health and wellbeing of children in is mixed compared with the England average. The infant and child mortality rate is worse than the England average.

The level of child poverty is worse than the England average with 21% of children under 16 years living in poverty. The rate of family homelessness is worse than the England average. Children in Derby have worse than average levels of obesity, nine per cent of children aged four to five years and 21% of children aged 10 to 11 years are classified as obese.

The service has relationships with a number of partner agencies, including other acute and specialist acute hospitals, general practices, local authorities, schools, clinical commissioning groups, the local authority, and voluntary groups.

Services are provided in health centres, sure start centres, schools, community buildings and in family homes.

During our inspection, we talked with 59 members of staff individually and in groups, 57 parents and six children and young people. We visited a special needs school, went out on visits with the school nurses and health visitors, observed community paediatricians, therapy staff clinic, and attended various educational programmes provided by the trust.

Our inspection team

The team that inspected services for children, young people and families consisted of one inspection manager, three inspectors and two specialist advisors.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive hospital inspection programme.

How we carried out this inspection

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?

We observed young people and their families receiving services and accompanied staff on home visits to children and their parents.

We also:

- Looked at nine clinical records
- Spoke with 57 parents or carers

Summary of findings

- Spoke with six young people using the service
- Held a focus group with a range of staff who worked within the service
- Spoke with 59 staff cross the service including the clinical director and operational manager for the

children and young people services. We also spoke with health visitors, school nurses, specialist nurses, administrative staff, physiotherapists, occupational therapists, and speech and language therapists.

Prior to and following our inspection we analysed information sent to us by the trust and a number of other organisations such as local commissioners and Health watch.

What people who use the provider say

Parents were overwhelmingly positive about the service provided.

Children and young people told us staff were kind and caring.

Good practice

- The Children and Young People's Neurodevelopmental Team improving services for neurodevelopmental issues including Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD).
- Single Point of Access multi-agency meetings prioritising the children with the most complex needs.
- The Cygnet programme parents of children with ASD attended a course to learn about the disability and

how to manage their children's behaviours, because of the benefits of the programme staff have extended invites to parents of children with learning disabilities.

- The attention deficit hyperactivity disorder ADHD parents programme to develop parenting skills to manage their child's behaviour and the follow up parents received from staff after the programme.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3).
- Staff who have contact with children must receive safeguarding supervision.
- The registered provider must ensure that staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.

Action the provider **COULD** take to improve

- The trust should ensure that the transcription of medicines is in accordance with trust policy.
- The trust should ensure that enteral feeds are administered in accordance with best practice medicines management procedures.
- The trust should ensure that infection prevention and control policies are adhered to with regard to robust system to establish equipment and toys have been cleaned.
- The trust should ensure all staff perform best practice hand cleansing techniques.

Summary of findings

- The trust should continue the recruitment drive to employ staff to further reduce waiting times for community paediatric appointments.
- The trust should ensure staff are aware of the trust's risk register, strategy, and vision for the future.
- The trust should ensure all senior staff are visible in all of the areas of the service.

Derbyshire Healthcare NHS Foundation 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 rated safe as requires improvement because;

- Safeguarding training attendance did not meet the trust target of 95%. Not all staff received three monthly safeguarding supervision by a member of the safeguarding team in accordance with “Safeguarding Children: ‘Roles & Competences for Healthcare Staff, Intercollegiate Document 2014”.
- Not all staff had completed trust mandatory training compulsory and non-compulsory.
- Medicines management practices were not in accordance with best practice standards.
- Infection control prevention policies were not adhered to at all times.
- Most staff were not aware of major incident contingencies and could not give an example of their role in such an event.

- The majority of staff did not have an understanding of their role and responsibilities under the duty of candour.

However:

- There were no never events reported in the previous 12 months.
- Staff received feedback from incidents. Learning from incidents was shared with all staff through regular team meetings and the electronic newsletter.
- Record keeping was good and documentation was in line with professional standards.
- Equipment was checked and available for staff to be able to carry out their role.

Detailed findings

Safety performance

- There were no never events related to children, young people and families in the community in the 12 months

Are services safe?

prior to the inspection. These are serious, largely preventable patient safety incidents that should not occur if available preventable measures have been implemented.

- Between 1 January 2015 to 31 December 2015, there were no serious incidents reported relating to this service.

Incident reporting, learning and improvement

- Incidents were reported electronically. Staff knew their responsibility in reporting incidents and were encouraged to do so. However, staff were not always reporting where they had experienced physical harm from young people, so the impact of this on staff could not be assessed.
- There were 57 incidents in total reported between January 2016 to June 2016. The largest cluster of incidents, 21 in total, related to 'Referral, Intervention, Transfer and Discharge', all occurred within the health visiting teams. Eighteen of the incidents related to 'Lack of information about patient/service-user'; three incidents were classed as 'moderate' outcomes; nine of the incidents related to antenatal appointment letters being sent to mothers who had miscarried and therefore caused distress to parents. Service leads were aware of the trend and had met with colleagues from other trusts nearby to improve the discharge information shared with the service to prevent this reoccurring.
- Action plans and learning was generated from incident investigations with a named individual for each action. The trust used 'incident handlers' who had an overview of incident investigations and actions. The incident handler chased actions and ensured action plans were completed.
- Staff said they received feedback from incidents through supervision, meetings, and newsletter emails. Staff could give us examples of where they had received learning from incidents. An example of learning from incidents was the introduction of prompts on the electronic patient record system to talk to parents about the risks to children ingesting button batteries.
- The trust had a serious incident review team who met weekly. The team had oversight of incident investigations and managers reported back progress to incident handlers.
- Staff had limited understanding of their responsibilities under 'Duty of Candour' (DOC) they were unaware of the

legal requirements, staff told us that they had not received training. This is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. We asked senior staff to review an example of DOC, but at the time of our visit there were not any incidents requiring DOC.

Safeguarding

- The trust had children's safeguarding policies and procedures available on the intranet. All of the staff that we spoke with were aware of the safeguarding lead and how to make a referral.
- There was an electronic system in place to highlight vulnerable and at risk children and families. We observed accurate records detailing plans of how the child and their family were being supported.
- Staff routinely talked to mothers about domestic violence, and we observed posters which provided information on where to get help. During a consultation we observed staff discussing domestic violence with a parent, the member of staff made an appropriate referral to support the woman and her children.
- A local protocol and training programme had been developed for health visitors and school nurses on the identification and reporting female genital mutilation (FGM). Staff were able to describe the process of reporting an incident.
- A community paediatrician was on call 24 hours a day for any safeguarding concerns. This meant they could respond to requests for safeguarding medical examinations promptly. The safeguarding team worked closely with the local hospital and had access to an appropriate room to perform safeguarding medicals.
- A child death multi-disciplinary serious case review panel reviewed all unexplained deaths of children and young people under 18 years old. On completion of the review findings were provided to the family, and lessons learnt shared through operational and team meetings.
- Staff told us, when a child attended the accident and emergency department the health visiting teams and the General Practitioner (GP) were notified, this ensured the child was followed up in the community.
- Staff required different levels of safeguarding training in relation to their role. Level one was the most basic level of training, with level three being required by those staff

Are services safe?

that provided care to children. Safeguarding children level one training completion rate was 98%, which met the trust target of 95%; however, 83% of staff completed safeguarding level two training, this did not meet the trust target of 95%. Safeguarding children level three training completion rate was 46%, so significantly short of the trust target of 95%. This meant that staff may not have the most current information to enable them to identify and report safeguarding concerns.

- The service could access a Safeguarding Children's Team. This team provided specialist advice, training, supervision and support for health care professionals so they carried out their responsibilities in all aspects of safeguarding children and acted as an expert resource to other agencies.
- Safeguarding supervision was not always performed in line with the trust's safeguarding policy. Staff told us this was often provided within their one to one sessions or at clinical supervisions, but was not given an allocated regular forum and not always documented. Some staff had not received formal safeguarding supervision with a member of the safeguarding team.
- Managers did not keep accurate records of how often staff received safeguarding supervision, this meant there was no assurances of staff receiving the recommended safeguarding supervision.
- Staff worked to safeguard children by collaborative working with multi-disciplinary and multi-agency teams including; Universal Services, CAMHS, Children & Young People Department, Local authorities, Police, Education and Specialist Services. Serious case reviews (SCR) were undertaken when a child or young person died or was seriously injured. Each SCR and the action plan were reviewed at bi-monthly meetings to ensure named individuals completed the actions allocated to them.
- Staff told us learning from SCRs was reported back through professional meetings, workshops and monthly educational sessions. Staff gave examples of learning from SCRs, including changes in practice in methadone storage after an incident where a child accidentally ingested it.
- The trust reviewed its Safeguarding Governance structures in early 2016 in line with the "Safeguarding Children: 'Roles & Competences for Healthcare Staff, Intercollegiate Document 2014" which states that the

Safeguarding Named Nurses and Doctors reports directly to the Executive Lead for Safeguarding Children. The 'Safeguarding Vulnerable Adults and Children Committee' now reported directly to the trust board.

- The service had introduced new training for staff to reduce safeguarding incidents 'Think! Family' principles. 'Think! Family' encouraged staff to look at the wider family in everything they do, and co-ordinate the support they receive across all services.

Medicines

- The trust had a corporate medicines management policy; this was available for staff to access on the trust intranet.
- No medicines were stored within the locations providing clinics, therapy groups or teaching programmes.
- Nursing teams based at school premises kept a stock of medicines on site. We found prescription charts were being transcribed (copied), by nurses with one signature; these were copied from treatment plans in the children's records which were completed by medical staff. The trust policy 'Transcribing Procedure for the Lighthouse Short Break Service and Special Schools' expired in June 2013 and was under review. This meant there was a risk of out of date non-ratified guidance being used.
- We observed staff taking enteral feeds (tube feeds which go directly into the child's stomach) to two, different children at once to save time due to staffing shortages. We escalated this to the manager who ensured this practice was discontinued immediately and treatments administered one at a time.
- Some staff in the community had completed the medicines prescribing course had not always put this extended role into practice, because they found it difficult to obtain prescription pads. This meant that another appointment was needed with their doctor.

Environment and equipment

- Clinics were provided at a variety of locations across the geographical area of Derby city. The majority of venues were not owned or run by the trust so responsibility for upkeep lay elsewhere.
- Equipment was checked and maintained according to manufacturers' instructions which ensured it was safe to use.
- Weighing scales were calibrated every six months to ensure they were providing accurate measurements.

Are services safe?

- Staff reported they could access equipment needed to provide the care to children and young people.

Quality of records

- The trust used an electronic record keeping system; this had been introduced to community teams six months previously. One school used paper records due to connectivity problems with IT systems. Staff were very positive about the system, telling us it had improved the service as having access to the same system enabled different professionals to share information effectively and quickly.
- Records were used by multi-agency members of staff and people were asked their at the first contact permission to share information across agencies
- We reviewed nine care records which were up to date, and reflected the needs of each individual child and young person. We saw examples where clinical staff had updated individual records immediately after each consultation. The records demonstrated effective interagency working for example, speech and language therapists (SALT) working alongside the community paediatricians.
- Entries in records were signed and dated, so followed good practice guidelines on record keeping from professional bodies such as the General Medical Council and the Nursing and Midwifery Council.

Cleanliness, infection control and hygiene

- All the places we visited appeared visibly clean and well maintained.
- Patient-Led Assessment of the Caring Environment (PLACE) assessments are self-assessments undertaken by teams of NHS and private or independent health care providers which include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, and supported non-clinical service areas such as cleanliness. In 2015, the trust scored 99% for cleanliness; this was above the England average of 97.6%. There was no specific data for the individual sites where core services were delivered from.
- An infection control policy was in place, 82% of staff has completed infection control training which did not quite meet the trust target of 85%.

- Signs were displayed in public areas such as clinic waiting rooms and treatment rooms emphasising the importance of good hand hygiene. We saw that not all staff adhered to good hand washing practices and did not wash or sanitise hands between each child.
- Some staff demonstrated a good understanding of infection control prevention and adhered to safe standards. However, in other areas, staff did not clean their equipment between each patient use. It was unclear in two areas if toys were cleaned after use because there were no signed cleaning schedules; this was not in line with the trust Policy and Procedure for Management of Communal Play Equipment.

Mandatory training

- The trust had a target rate of 95% for compulsory courses and 85% for mandatory and non-mandatory courses. Compulsory courses included information governance, equality and diversity, moving and handling training and safeguarding level one and two (adults and children). Mandatory training included basic life support; level three safeguarding training, Mental Capacity Act 2005 (MCA), and Deprivation of Liberty Safeguards (DoLS). Compulsory training was corporate training, and mandatory was more role specific.
- The trust overall compliance rate was 89% for all compulsory courses. Across the children's and young people's service the compliance rate for mandatory training was 63%. Combined compulsory and mandatory training together was 76% compliance, so this did not meet the trust target.
- All staff we spoke with said they were up to date with their mandatory training; however this was not reflected in the training statistics provided by the trust. Staff were responsible for managing their own training and booking on courses. Staff used an electronic system which kept a record of courses they had completed. Managers monitored staff completion rates of training and used a traffic light system which indicated if training had been completed, due, or overdue.
- Staff told us course availability was an issue and it was difficult to get a place on training days, staff valued being able to complete training on line.

Assessing and responding to patient risk

- Staff told us they had access to urgent medical advice 24 hours a day if they felt the need to escalate any concerns.

Are services safe?

- We observed risk assessments for a variety of health conditions in medical records along with plans of care. For example, where children had epilepsy, the type of fits the child experienced was recorded and the treatment dosage of medication to control the fits was documented.
- All children seen by the health visiting teams were assessed using an evidence based assessment framework.
- Children or young people with a medical condition were included, with their parents, in a multidisciplinary approach to teach them how to recognise the symptoms which would cause their child's condition to deteriorate. It was offered in a group setting or one to one depending on the family's needs.
- Paediatric basic life support (PBLIS) training did not meet the trust target of 85%, as 68% of staff had completed the course. We discussed this with the management team who did not agree with the statistics we were given they were assured that local statistics demonstrated 100% of staff were trained. Seventy percent of staff had completed adult basic life support (BLS) training; this did not meet the trust target.

Staffing levels and caseload

- The service had a number of different clinical teams including; health visitors, school nurses, physiotherapists, occupational therapists, the looked after children nurses, community paediatricians, neurodevelopment team and the learning disability team.
- Health visitor staffing was allocated on a 'deprivation score', each caseload were on average 352 families, this was higher than the recommended case load level of 250 families. Visits were allocated within teams on a weekly basis.
- There were 2.71 WTE specialist health visitors who worked with children under five with a learning disability their caseload was 86 families. This meant those families had continuity of care and the health visitors were trained to support specific health needs.
- The health visiting team used bank staff, between December 2015 and February 2016, forty two shifts were filled and two were not covered. There were only two health visitors on the bank therefore there were not enough bank staff to backfill all of the shifts.
- Community health services for children, young people and families has the highest qualified nurse vacancy

- rate of 41%, the nursing assistant vacancy rate was 0.4%. The teams were supported by bank staff and staff working extra shifts. They were advertising to recruit more staff.
- The schools therapy team had the highest substantial turnover rate (for a team of ten or more) at 15% which is higher than the trust average of 10%. Eight of the 19 teams have turnover rates higher than the trust average and eight had a turnover rate of 0%.
- NMET Nurse Training has the highest vacancy rate of 54% which is more than five times the trust average of 10%, although the team had a small team of ten staff.
- Seven of the 19 services have sickness rates above the trust average.
- Managers said they have some zero hour contract nurses to help backfill where there were shortages.
- Staff described the impact of staff vacancies and sickness meant they were unable to provide as many clinics and contacts with children and young people as they would have liked.

Medical Staffing

- There was a shortage of community paediatricians, in May 2016 there was a vacancy rate of 3 whole time equivalent paediatricians. The service was using a regular locum, who was known to the service, and was redesigning pathways and trying to work smarter to minimise any impact the shortage had on the service.
- Managers told us it had been difficult to secure appropriate temporary workforce cover, the service had been operating with vacant posts for some time. The recruitment for permanent members of staff was on-going.
- We observed an action plan developed and discussed at monthly team meetings which highlighted the difficulties the service had with recruiting suitable staff. They were implementing innovative ways of working and example was the neurological nursing team who reviewed children which freed up the paediatricians time.

Managing anticipated risks

- A lone worker policy was in place across the trust. Staff told us they followed the policy and were not concerned about remote working. Staff were issued with mobile phones, which meant staff could have contact with their

Are services safe?

office base and colleagues during working hours. There was a code word which staff knew and could use during calls which alerted other staff that were concerned about their safety.

- Staff felt confident that effective systems were in place to reduce the risk to staff who worked alone. These included check-in arrangements and when concerns had been identified, joint visits were arranged.
- The staff we spoke with during this inspection were aware of the lone working policy and the measures they needed to take to maintain their own safety during home visits.

- Staff we spoke with were not aware of any plans to anticipate risk such as adverse weather or staff disruptions.

Major incident awareness and training

- The trust had a major incident and emergency policy in place. The majority of staff we spoke with had mixed understanding of what was considered to be a major incident. Some staff explained contingency plans for bad weather.
- Fire safety training had been delivered to 86% of staff which met the trust target of 85%; each location we visited had a fire procedure and evacuation route displayed.

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.

Summary

We rated community health services for children, young people and families as 'good' for effective because;

- Assessments care and treatments were delivered in accordance with best practice, evidence based policies and guidelines.
- We observed excellent examples of multidisciplinary, multi-agency collaborative working with children, young people and their families.
- Consent was always sought appropriately dependant on the circumstances, from parents, children and young people.
- Staff at all levels demonstrated their commitment to work in partnership with others to achieve the best possible care for children, young people and their families.
- Services met their performance targets with very few exceptions.

However;

- Not all staff had completed an appraisal; the trust target of 95% had not been met as 74% staff had received an appraisal in the past year.

Detailed findings

Evidence based care and treatment

- Policies and guidelines were based on the latest evidence and best practice. Policies and guidelines were easily accessible for staff on the trust intranet. Staff we spoke with across the service were aware of the national guidance relevant to their practice.
- We reviewed five policies; Medicines management, Lone working, Procedure for the Lighthouse Short Break Service and Special Schools, Supervision Policy and Procedure and Did Not Attend/No Access Visit Policy. All except one were in date, ratified, version controlled and referenced to best practice documents and guidance.
- Children, young people and their families received care, treatment and support which achieved positive

outcomes. Staff promoted healthier lifestyles choices to improve good quality of life, based on the National Institute for Health and Care Excellence (NICE) or other national or international recognised guidance.

- The Children and Young People's Neurodevelopment Team and paediatricians had developed an attention deficit hyperactivity disorder (ADHD) pathway. The audits of the pathway showed benefits to children, young people and families. The benefits included; reduced waiting times to access care, increased choice, greater involvement of all of the family, increased knowledge of the condition ADHD. The benefits for the service were optimising skill mix and resource use, reducing waiting times, increased multidisciplinary team working, appropriate medicine management of the condition and good clinical governance.
- The service was participating in an audit 'Prescribing for ADHD in children adolescents and adults'. This was on-going at the time of our visit and was due to complete November 2016.
- Staff told us of an audit of interagency information sharing between the midwife and health visiting teams; this had specific regard to children with parents who had mental health needs. The outcome was improved multidisciplinary liaison, better documentation and completion of an early assessment of the mother and/or father during pregnancy, the aim was to identify any additional needs and actions to protect the unborn child.
- An audit in progress was the global developmental delay of unknown cause in preschool children to determine compliance with the 'Glasgow recommendations' which was to ensure children received appropriate investigations, and improve history taking and documentation.
- The Family Nurse Partnership (FNP) programme provided families with an intensive, evidence based preventative programme for vulnerable first time mothers under the age of 20 years, from pregnancy until the child was two years of age. Family nurses delivered the licensed programme with a well-defined and structured service model.

Are services effective?

- School nurses delivered the national child measurement program (NCMP). This records the height and weight of children in reception class (aged 4 to 5 years) and in year 6 (aged 10 to 11 years) to identify overweight and obesity levels in children within primary schools. School nurses do not offer the childhood vaccination program as the service is not commissioned. The vaccine protects against cervical cancer and was offered to girls in year eight (aged 12 to 13) in school.
- The looked after children nurses (LAC), supported 'looked after' children (children within the care system), to improve their health and life chances. Staff provided a holistic health educational approach to health assessments and contributed to strategic planning designed to raise the profile of children and young people within the care system. One young person ready to leave care told us they felt supported to make this transition.
- An audit in 2015 of the baby safe programme was performed to evaluate if staff had explained the two, baby safe programmes known as 'Baby Safe Sleep Assessment' and the 'Non Accidental Head Injury' parent education programme called "Shaking the baby is just not the deal". The results showed that families could remember having the information for the two programmes.

Nutrition and hydration

- The trust were Baby Friendly Initiative (BFI) fully accredited in April 2015, and consistently performed better than the trust target of 40% of mothers who were still breastfeeding six weeks after birth. Between February 2015 and January 2016 the trust performed better than target for 10 months out of 12 averaging 43%. The percentage of mothers' breastfeeding and using supplements was an average of 71% for the same period against a trust target of 65%. This meant mothers received best practice advice to support them to keep breastfeeding their baby to improve health outcomes.
- To demonstrate standards had been maintained the service completed an audit using the BFI audit tool. All of the standards continued to be met, which meant mothers were receiving evidence based infant feeding advice from the health visiting teams.
- Health visitors and school nurses discussed healthy eating with families to reduce rates of obesity.

- Staff referred children to the dietician if specialist advice was required for diabetes or allergy related illnesses.

Technology and telemedicine

- Staff contacted families by telephone to make appointments.
- Telephone assessments were performed by some clinicians prior to the child's first appointment, this enabled them to focus on the assessment during their appointment.

Patient outcomes

- The service provided all of the core requirements for the Department of Health's 'Healthy child programme'. This includes early intervention, developmental reviews, screening, and prevention of obesity and the promotion of breast feeding.
- The total number of new births visits within 10 to 14 days against the total number of new births varied between 97% and 100%. The average for the period February 2015 to January 2016 was 99% so this showed an improving picture.
- The average percentage of mothers visited to review breastfeeding between six and eight weeks (for the period February 2015 and January 2016) was 99% against a trust target of 95%. Four months out of the 12 staff had visited 100% of mothers. This meant that mothers were given information and support to continue breastfeeding.
- The health visitors completed around 150 antenatal visits each week; this did not meet the trust target of 250 weekly. Staff told us that this was due to staffing levels and that they were positive that it would improve with the recruitment of more staff.

Competent staff

- All of the staff we spoke with told us they had attended an annual appraisal. We received mixed comments from staff, some found appraisals very useful to discuss their issues and to plan their objectives for the following year and others described it as a paper exercise. The appraisal rate for the service was 74% in the last 12 months. This was lower than the trust's target of 95%.
- At the end of January 2016, 102 doctors had been revalidated across the trust which equated to 92% overall. Information relating to specific core services was not made available.

Are services effective?

- The trust set a clinical supervision target of a minimum of 10 hours per annum, for non-medical staff. Clinical supervision data received for 12 teams in this core service showed overall compliance for the core service is 46% which does not meet the trust target. However all staff we spoke with told us they received regular clinical supervision every other month.
- Staff said they were encouraged and supported to access additional training to develop their knowledge and skills. Development opportunities were discussed and identified in supervisions and personal development reviews.
- New staff were mentored by more experienced staff. For example, the newly qualified health visitors were mentored by more experienced health visitors whilst they gained confidence and completed their preceptorship pack. New staff from other areas completed a staff induction pack.

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary working and collaborative care was evident across services. An example of this was the Single Point of Access (SPOA) initiative; this is a one stop shop to triage referrals to ensure the child had the best possible treatment for their particular needs. The services attended weekly meetings were Child and Adolescent Mental Health (CAMHS), Community Paediatricians, Clinical Psychology, School Health, Multi Agency Teams and Relate (a relationship counselling service) were present.
- The ADHD and ASD care pathways were developed through a multi-professional and multi-agency approach. The care pathways were comprehensive from initial assessment, treatment planning to parent training programmes and follow up. The ADHD specialist nurses were involved in training and advising schools.
- The health visiting and school nursing teams worked in partnership with other staff and agencies on a daily basis, including Voluntary agencies; sure start staff, General Practitioner (GP), Local authorities, Midwives and Education.
- All staff we spoke with were confident to escalate and share concerns with other professionals to ensure care was integrated and coordinated effectively for the child's individual needs.
- Health visitors and Midwives met quarterly to review current issues and new initiatives. We read minutes

which highlighted areas of care to be improved, for example; communication from midwives to health visitors reporting women who were no longer pregnant, completion of notification forms and handover forms.

Referral, transfer, discharge and transition

- There were processes for transferring children from health visitors to school nurses. Transfer summaries were documented for children who were diagnosed with a medical condition, had safeguarding concerns or child in need concerns.
- Therapy staff had a pathway of care to discharge children. We observed a planned transition with the therapist and mother of a child moving to secondary school. It was sensitive to the child's needs and the families concerns.
- At the time of our visit there were no joint children's and young people clinics running alongside adult clinics to transition them to adult services. Managers told us they were aware this needed to be developed to enhance the service, and that work had not yet commenced on improving this service.

Access to information

- The trust introduced an electronic recording system September 2015. Staff we spoke with reported an improvement in communicating with other health professionals and being able to review other service reviews of the child.
- Staff could access the trust intranet which contained links to guidelines, policies, standard operating procedures and contact details for colleagues within the organisation. This meant staff could access advice and guidance easily.
- We observed the personal child health record or 'red book' being used; this was given to parents following the birth. The red book held medical information about a child from birth to four years of age and recorded child, family and birth details, immunisation records, screening, routine reviews and growth charts. Accessibility to electronic records and clinical record keeping was compromised for staff based at non NHS locations, such as special schools due to poor internet connections. Two sites were identified where this was a particular issue. Staff kept paper records for children receiving treatment within those schools.

Consent

Are services effective?

- We reviewed nine care records which demonstrated consent had been obtained for care and treatment.
- Staff understood and were able to explain both Gillick competency, and Fraser guidelines. Gillick competency and Fraser guidelines refer to two legal cases, which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16 year olds without parental consent.
- School nursing staff worked within Fraser and Gillick guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves.
- We observed staff asking the child and parent for verbal consent before an examination or therapy commenced.



Are services caring?

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

Summary

We rated community health services for children, young people and families as 'outstanding' for caring because;

- Overwhelmingly, we received feedback indicating care was excellent and compassionate and reported being treated with respect and dignity and having their privacy respected at all times.
- We observed strong person centred care. Staff demonstrated exceptional values working in partnership with children, young people and their families.
- Staff empowered and supported people to have a voice and choices were acted upon where possible.
- Staff built meaningful relationships and ensured children, young people and parents understood the care and treatments they received.
- We were told staff were valued by children, young people and families and that they felt staff really cared and nothing was too much trouble.
- Staff were extremely passionate about delivering kind, empathetic care to children, young people and families.

Detailed findings

Compassionate care

- Feedback about the service was consistently positive. Parents told us for example: 'They have never failed us and have been fantastic, all the staff want the best for the child', 'We feel safe, they are warm and friendly', 'She is amazing not just as a doctor but has been personally supportive of me as a mum'.
- We observed excellent interactions and communication between staff and children and young people, and their parents or carers. Staff were skilled in caring for children and young people, and their approach was relaxed and compassionate. We observed staff remaining calm and reassuring with children and parents that were very worried at their appointments specifically those awaiting a possible diagnosis.
- All staff we spoke with or observed in practice demonstrated children and young people were at the heart of what they do. Staff were fully committed to providing exceptional standards of compassionate care.

- Staff were able to build up relationships with children and their families and were attentive to the needs of the parents when caring for their children.
- We attended several clinics where staff had an excellent rapport with young people and were sensitive to their needs. An example was a member of staff taking time to explain a report to a child who was not happy with it. Following the explanation the young person understood why it had been written.
- We went on home and school visits with the health visitors and school nurses. Staff were aware of their clients' past and present history and of any impact this might have on their current care. We observed a lovely manner a school nurse had with a young person when dealing with a sensitive hygiene issue.
- Staff were experienced in responding to non-verbal communication from young children and children with a learning disability, they were able to change their approach accordingly to make them feel as comfortable as possible.
- The parents we spoke with all confirmed positive interactions from staff. We observed therapy staff using these skills when assessing a child. The child was shy and reserved at the beginning of the session stating they were scared, at the end of the session they were happy and gave the therapists a double thumbs up.
- In relation to privacy, dignity and wellbeing, the 2015 PLACE score for Derbyshire Healthcare NHS Foundation Trust was 95%, which was above the England average of 86%. There were no specific scores for the service.
- Children, young people and their families were treated with dignity and respect. At home visits staff respected the wishes of the home owner asking permission to enter and where they should sit.

Understanding and involvement of patients and those close to them

- There was a strong emphasis on person centred care, staff worked in partnership with children and young people to find ways to provide care that would engage them. We observed a member of staff sensitively encouraging a young mother from another country with no friends to attend a clinic or group to enable her to make friends.



Are services caring?

- We observed staff helping children and their families understand the treatment and support available to them. Staff ensured parents understood what was going to happen and why at each stage of their child's treatment.
- When required staff promoted independence for children and young people involving the parents to improve self-esteem of the individual.
- The neurodevelopment team had a range of information which they used to enhance the discussions; we observed staff going through information to ensure the child and parent understood the care they were receiving. This included behavioural techniques to manage children with ADHD and ASD. A parent told us 'The paediatrician kept me sane, attended all of the appointments with school and always finds the time to go the extra mile'
- We saw excellent interactions where staff empowered parents and children to speak out and directed them to other services to get the support they needed for their child. A parent told us how a therapist had accompanied her to support her and her child with a disability to obtain a specific piece of equipment which would improve the child's quality of life and self-esteem.
- Parents told us staff had excellent ways of explaining the care their children were receiving and they were able to contact staff if they did not understand any treatments or therapies. We were told by a parent 'The health visitor is lovely and helpful and answered all of my questions'.
- Staff empowered parents to have a voice and speak out for their child. A parent explained 'The paediatrician always finds time in a crisis, they are always involved in our child's care and the paediatrician encourages us to speak out at meetings'.
- The trust used a face to face translation service which all community teams could access; over 60% of visits required a translator to attend. Staff said care was greatly improved by using a face to face translation service.
- Staff respected people's choices and gave options where possible. At a home visit we observed a mother being offered a range of options regarding her diet that would support and encourage healthy eating.
- We received 17 feedback card comments all were positive parents said 'staff were kind and friendly' 'Toys to keep children occupied, short waiting'
- One parent was very positive about the care her child received at school and told us she was blessed to have the team caring for her child in school and if there are any care issues she was confident the nurses would call her straight away.

Emotional support

- Parents of children with complex conditions said the therapists were helpful and considered the needs of the entire family as well the individual child. Parents welcomed the support given which helped the child progress to school. Children with complex needs were nursed in school which prevented them having time out for treatments and appointments it also supported their emotional wellbeing.
- We observed staff teaching parents about the early attachment theory, which improves the emotional development of children and bonding between parents and their children.
- Young people in schools received timely emotional support, the school nurses ran drop in sessions. They could have support on any issues that were causing them to worry. We observed a busy clinic and the school nurse was exemplary in the care she gave to emotionally support the young people who attended.
- Staff provided holistic care and had an awareness of all family members and any additional support the family may require. We observed a visit to a complex family and the staff member was sensitive to the emotional needs of each member of the family.
- We observed the Cygnet programme (teaching parents how to care for children with ASD) being delivered and staff encouraged emotional support for parents by asking them to bring pictures of their child to refer to as the training was being taught.
- We observed excellent caring interactions from nurses to children in care. We spoke with a young person who said 'the team were supportive and approachable'.

Are services responsive to people's needs?

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

Summary

We rated community health services for children, young people and families as 'requires improvement' for responsive because;

- There were long waiting times for appointments to see community paediatricians.
- The time from being seen and the onset of treatment was longer than recommended.

However;

- Children, young people and families had a choice of services at various locations and times to access health care and or support.
- The service understood the different needs of the population it serves and designed services to meet those needs.
- The service promoted person centred care, good health and wellbeing.
- In most clinics children, young people and families were encouraged and supported to feedback or make a complaint about their care.

Detailed findings

Planning and delivering services which meet people's needs

- The service met the needs of the population. Clinics, drop in sessions, support groups and teaching programmes were available at various venues across their geographical area to enable good access for families. Staff also offered home visits.
- School nurses ran drop-in clinics in secondary schools. Young people attended, and discussed issues such as; depression, self-harming, stress, contraception, positive pregnancy tests, sexually transmitted infections, alcohol, drugs, puberty, and bullying.
- The occupational therapist and the physiotherapist ran joint assessment appointments to prevent the child having to attend two appointments; staff told us they ask very similar questions. We observed an assessment which prevented the parents having to give the history twice and prevented them having to answer the same questions with two different therapists.

- The children's continence service had a range of leaflets to support advice given to parents and children. Advice leaflets were available in different languages if their first language was not English.
- The trust website had useful information and explained all of the different children and young people's services. It also signposted families to other agencies.
- Physiotherapy and Occupational therapy staff ran 'Therapy in the Early Years Group' which monitored and provided therapy for children with developmental delay, and social support for families. Staff asked parents for feedback and had responded to a theme by enabling children over the age of two to attend the group.
- Disabled Children's Community Nursing Service provided training for parents of children with Autistic Spectrum Disorders (ASD). The Cygnet programme is accredited by Barnardo's, because of the benefits of the programme staff have extended invites to parents of children with learning disabilities.
- An innovative approach was developed for refugee and ethnic minority families, when they arrived in the locality they were prioritised to be seen by a member of the health visiting team. There was a parent group which helped with speech and language skills, which staff signposted families to.
- Baby massage groups were offered locally for parents to access. These were delivered by nursery nurses trained to teach parents how to massage their babies. This promoted emotional wellbeing and strategies to manage an upset or crying baby.
- The specialist school hosted a range of services in the school to meet the needs of the children and families for example; hydrotherapy treatments, occupational therapy, physiotherapy, nursing interventions, and a paediatric clinic.

Equality and diversity

- The staff we spoke with had a good understanding of the population who used the service and were able to explain the specific needs of the people they cared for in relation to equality and diversity.

Are services responsive to people's needs?

- There were a number of areas that had high levels of deprivation and ethnic minority groups. We observed staff treating children, young people and parents equally and respectfully.
- Staff told us they had good access to face to face interpreting services for people whose first language was not English.
- Staff told us they promoted equality and provided equal inclusion and equitable treatment for all children and young people, which improved health outcomes.
- We observed staff treating people holistically taking into account their disability, race and religious beliefs. For example we observed a health visitor at a home visit asking a mother from another country about her family dynamics and social interests.

Meeting the needs of people in vulnerable circumstances

- Looked after children's nurses offered confidential support to children in care and their foster carers, they listened and gave non-judgemental advice, they also carried out health reviews in partnership with medical staff. The nurses had developed partnerships with many other health professionals, including hospital paediatricians, contraception and sexual health (CASH) teams, the trust's Child and Adolescent Mental Health Services (CAMHS) team and Breakout team (young people's substance misuse team).
- Health visitors were allocated a foster carer to their caseload to ensure continuity for the carer looking after babies, children and young people.
- The specialist health visitors worked with children under five who had a disability and required care above the universal pathway. The team worked across all localities to support the children and their families.
- Staff signposted families to groups and other agencies to support their needs and to improve outcomes for those families.
- The specialist schools provided a nursing service to children with complex health needs to ensure their education was not disrupted. The team provided on average 100 regular medical interventions which included gastrostomy feeds (tube feeds directly into the stomach), naso-gastric feeds (tube feeds), medication administration, intermittent catheterisations (to enable urination), tracheostomy care (suction of a tube that enables breathing), emergency epilepsy care (treatment

- of fits), first aid and many assessments. The aim was to ensure that any child, regardless of the complexity of their needs, could access education and had the same opportunities as any other child.
- The disabled children's nursing service developed a newsletter every two months for colleagues to raise awareness of disabled children's issues. The newsletter contained information on various medical conditions and disabilities with places of interest to signpost children and parents. The February 2016 edition focused on the condition Foetal Alcohol Spectrum Disorder, (an umbrella term for several diagnoses that are all related to an unborn baby being exposed to alcohol in the womb), annual health checks, continence information, communication strategies, a day in the life of a staff member, a parent/child story and spotlight for Downs Syndrome (DS) Awareness Week.

Access to the right care at the right time

- Referral to therapy services was less than 18 weeks which met the trust target. One family attending the service told us they had waited six weeks.
- Children and young people had long waits between referral, initial assessment, and the onset of treatment for some services particularly ASD referrals. Referral to onset of treatment for community paediatric services and specialist nursing for children in care provided the longest waits with an average of 321 days and 387 days respectively. The average waiting time for referral to assessment was 165 days, and 102 days between initial assessment and onset of treatment this is higher than the recommended times.
- Managers had implemented a number of initiatives to reduce waiting times. Referrals were reviewed at the SPOA and staff prioritised urgent referrals by conducting telephone risk assessments.
- We observed an action plan and minutes from monthly meetings to reduce waiting times and mitigate the effect on families.
- To mitigate delays in waiting for treatment staff signposted patients and families to other services where support was available whilst waiting for treatment. Staff also developed and innovated additional support tools for children for example, hand Olympics to improve and develop fine motor skills whilst waiting for treatment.

Are services responsive to people's needs?

The neurodevelopmental team of specialist nurses were trained in prescribing medications and performed the ADHD assessments; this gave the paediatricians more time to focus on other referrals that only they could see.

- Staff told us they facilitated extra clinics on Saturday mornings to provide additional clinical capacity, however uptake was poor. There had been changes made within the current workforce to maximise the provision of clinics which had targeted the areas with the longest waits.
- The service leads explained they are working with another provider to develop a multi-agency assessment process to avoid unnecessary duplication and facilitate greater use of resources within both health care services. We were told there was an opportunity to fast track the implementation of these initiatives with non-recurrent funding from commissioners.
- We observed a paediatric performance report which demonstrated to the trust board and commissioners the 'did not attend rate' between April 2015-March 2016 was minimal at 0.3% for children's services. During that time new appointment demands were exceeding capacity by 6%.

Learning from complaints and concerns

- The trust had systems in place for children, young people and their parents or carers to raise their concerns or complaints. Information on how to provide their feedback was displayed in most of the locations we visited during our inspection.
- Parents and children could also make complaints directly to the trust Patient and Liaison service (PALS) or leave feedback on the trust website.
- Staff could explain what actions to take when concerns were raised and how they tried to resolve any problems as soon as they were raised which often prevented a formal complaint.
- Between February 2015 and January 2016 the service received a low number of complaints, six in total three were fully upheld and three partially upheld.
- Two complaints related to excessive delays in accessing community paediatric services for their children.
- Four of the six complaints referred to the length of waiting times.

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 rated community health services for children, young people and families as 'requires improvement' for Well Led because;

- Staff were not able to explain or give examples of the trust strategy, statement of vision or values
- Staff were not aware of risks to the delivery of quality and there was no local ownership of risks to the service.
- Managerial leadership was not strong there was no assurance or oversight of staff initiatives locally or that staff had completed appropriate clinical or safeguarding supervision.
- The service had been awarded by Public health following a tender exercise the new service model was in an active mobilization of a new contract model. In this period there was not a full time manager locally, in this period senior staff had been given designated days within their current roles to complete managerial tasks.
- The executive team and senior management were not visible locally.

However;

- The trust has a strategy, vision and values which are reviewed regularly.
- Staffs were supported to be innovative and take action to improve services to local need.

Detailed findings

Service vision and strategy

- The trust had clear strategic objectives which concentrated on delivering quality services and putting patients at the centre of them. The trust developed four strategic outcomes that were about the nature of care people who used services should experience. They were:
 - Outcome 1: People receive the best quality care
 - Outcome 2: People receive care that is joined up and easy to access
 - Outcome 3: The public have confidence in our healthcare and developments

- Outcome 4: Care is delivered by empowered and compassionate teams
- The trust vision was underpinned by four values developed in partnership with patients, parents/carers, staff and stakeholders. The four values included putting patients at the centre of everything the trust does, focussing on staff and involving them to make decisions and delivering excellence.
- The trust strategic objectives were monitored and reported in the public session of the trust board every quarter.
- Children's services had developed four work streams based on the trust vision. They were:
 - To improve the outcomes for early help and prevention by moving to integrate the early help prevention model across relevant 0-19 services.
 - To improve the response to children and young people who have neuro-developmental difficulties including ADHD and Autism.
 - To implement a community-based CAMHS liaison service across South Derbyshire Unit of Planning.
 - To reduce the number of children attending and being admitted to hospital and identifying high risk cohorts.
- However, most staff had minimum knowledge of the trust strategy and of their service work streams, the majority told us changes were happening but they did not know what the service would look like after July 2016.
- The trust had developed a safeguarding children strategy for 2016-17 which highlighted priority areas to better protect children and young people from harm and abuse.

Governance, risk management and quality measurement

- The trust had a quality framework and strategy which set out how the trust would measure and discuss governance, its structure (including committees and groups), and quality.
- A summary of each Quality Committee's business is presented to the trust board of directors each month including those areas requiring escalation to the board.

Are services well-led?

- Board members undertook quality visits to gain an understanding of how teams and services operate. All teams within the trust are visited once a year by board members and senior managers with a focus on their individual quality.
- The service had 61 open risks on the trust risk register. Fifty six of these (92%) were classed as either very low or low risk (current risk level). Of the four moderate risks, three related to the 'Therapy & Complex Needs' directorate and one related to 'Schools Nursing'. The issues of waiting times and vacancy for paediatric staffing is on the children and young people's risk register.
- Only one of these four moderate risks has increased in risk level since being added to the register which was the risk relating to 'Schools Nursing'. This started as a low risk and had increased to moderate. The title of the risk was, 'Shortage of specialist practitioners in school health and difficulty in appointing registered nurses'. The description of the risk and controls which were in place were detailed in the source document. However, there are no open actions listed against this risk.
- For the remaining three moderate risks under the 'Therapy & Complex Needs' directorate they are as follows:
 - Unable to double check medications for under 12's due to staff levels.
 - Work related stress for Children's Therapy Teams.
 - Medicines Management - including Controlled Drugs.
- The extreme risk is for the 'Community Paediatrics' directorate), and was, 'Long waiting lists following reduction in staffing levels'. The description and controls which are in place are detailed in the source document. There is one open action listed against this risk.
- Therapy and complex needs directorate had the highest grouping of risks, with 39 out of the 61. The breakdown by risk type could be seen below for all of the directorates.
- In terms of risk subtype, 'Clinical risk – Other' was the highest risk subtype with seven risks. Six of the seven were within the therapy and complex needs directorate. All seven were either classed as low or very low risk.
- Staff were not able to describe risk at a local level, and could not give an example of a risk on the trust risk register. Therefore, it could not be ensured that risks were being managed at all levels of the organisation.
- Staff knew their manager and the senior management of the service, and a few staff were aware of members of the trust executive leadership team.
- Staff were positive about the skills, knowledge and experience of their immediate managers and felt they were well supported. However, staff felt there was a disconnect between the trust board and staff providing community services for children, young people and families. Staff felt the board were not visible.
- Local leadership was strong however the matrons of the services did not have good strategic oversight of their teams training and competence specifically relating to safeguarding training and supervision.
- There was not a full time manager locally, senior staff had been given ad-hoc days within their current roles to complete managerial tasks.

Culture within this service

- Staff we spoke with described a supportive culture and said they supported each other. Staff enjoyed working with each other and valued their teams. Staff said when they had capacity issues they pulled together and supported each other and other teams.
- All staff we spoke with were proud to work for the service, enjoyed their role, and were enthusiastic to continually improve services that they delivered.
- Staff told us they felt confident if they needed to contact their line manager or senior managers if they had concerns.
- All staff we spoke with were extremely passionate about the care they gave to women and their families.

Public engagement

- Staff recognised the importance of receiving the views of people who used the service and encouraged them to complete feedback forms
- The service held monthly parent participation meetings. We observed minutes of meeting which discussed allocating parents to various work streams; one parent shared their experience of being part of a staff interview panel.
- People who used the service could leave feedback on the hospital website. We reviewed the website and it invited people to share their experiences.

Staff engagement

Leadership of this service

Are services well-led?

- Staff told us they were encouraged to be involved in how the service was delivered and were able to feedback any comments or concerns they had. We reviewed a document which contained feedback themes from staff from the engagement events.
- Staff told us they were encouraged to engage with senior managers to promote their ideas to improve the service.

Innovation, improvement and sustainability

- The development of the single point of access service had minimised risk to children waiting to be seen.
- The service had improved the attention deficit hyperactivity disorder (ADHD) services to a nurse led model had demonstrated improved quality, reduced waiting times and reduced costs.
- Health visitors were successful in being awarded funds from the trust innovation network bid. The money was used to implement a prevent children getting dental caries initiative. All the children in the area were targeted via nurseries, schools and groups.
- The Disabled Children's Community Nursing Team developed an initiative to promote sight awareness in schools, and plan to visit schools annually.
- Nursery nurse staff promoted the 'Physical Literacy Programme' (competent physical literacy is a child who has good physical development with well-developed gross and fine motor skills for their age) health promotion in schools and work with area school clusters. This programme helps children with poor central core stability to improve issues such as;
 - Improved ability to concentrate
 - Improved core stability and shoulder stability
 - Improved fine motor skills and handwriting
 - An increased enjoyment of being active
 - An improvement in their emotional health and wellbeing
 - Choosing to remain active throughout their lives

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

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

The registered person must ensure service users are protected from abuse and improper treatment.

How the regulation was not being met:

- The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3).
- Staff who have with contact children must receive safeguarding supervision.
- The registered provider must ensure that staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.