Black Country Partnership NHS Foundation Trust

Community health services for children, young people and families

Quality Report

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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)
TAJ	Delta House Trust Head office.		
	Brierley Hill Health and Social Care Centre		
	Kingswinford Health Centre		
	Halesowen Health Centre		
	The Sunflower Centre		
	Coseley Health and Family Centre		
	Cross Street Health Centre		
	Ladies Walk Clinic		

This report describes our judgement of the quality of care provided within this core service by Black Country Partnership 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 Black Country Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Black Country Partnership 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?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service

The overall rating for this core service was requires improvement.

We found areas of safety to require improvement. For example, we saw that clinical equipment within patients' homes was not consistently maintained. We also saw risks in relation to staffing levels in the Health Visiting Team.

The service had robust safeguarding procedures in place, and that learning from incidents was being shared with staff in a number of formats including by email and through discussion at team meetings, however not all staff had received appropriate safeguarding children training.

We rated the effectiveness of services as good. Evidence based practice was delivered across all services and that national programmes of care were followed. Staff assessed patient needs thoroughly before care and treatment started and staff took part in competency based training programmes.

Across all community Children, Young People and Families services staff provided an outstanding level of caring. When speaking to children, parents and carers they were continually positive about the care that was provided and the way that staff treated them. People told us and we saw that staff went the extra mile when they provided care. Staff were committed to empowering young people through providing them with appropriate information and support to enable them to make decisions around the care they received. Children, young people and their carers told us that they were treated with compassion, dignity and respect. They were involved in discussions about treatment and care options and able to make decisions. Information was provided in a number of formats to enable young people to understand the care available to them and help them to make decisions about the care they wanted to receive. Staff within services went beyond the remits of their role to overcome obstacles on numerous occasions to ensure the needs of the child, family and carers were met.

The core service were responsive to people's needs. They were tailored to the needs of local populations and most staff were able to access training specific to the needs of the populations they supported. Care was provided from a number of settings and at flexible times to increase the accessibility of the service being provided.

We concluded that the core service required improvement in the well-led domain. There was disconnect between the senior management team and staff within community Children, Young People and Families services. We saw strong local leadership with the majority of staff we spoke to telling us that they felt supported by their direct line manager, but less so from senior managers or the executive team. For example, senior managers had not supported the Health Visiting team with additional resources to manage a caseload that had quadrupled in size over the last 12 months. Staff were struggling to cope daily and we were not assured children and families were protected against abuse and avoidable harm. Leaders were unaware of significant issues threatening delivery of safe and effective care.

Summary of findings

Background to the service

Background to the service

Community services for children, young people and families between the ages of 0 and 19 years.

Black Country Partnership NHS Foundation Trust provided a range of services for children and young people across Dudley and the adjacent localities to include:

- Children's Occupational Therapy
- Health visiting
- Family Nurse Partnership
- Haemoglobinopathies Service
- Paediatric Physiotherapy Service
- Palliative Care
- Speech and Language Therapy
- The Children's Assessment Unit

During the inspection, we spoke with 63 members of staff, 20 parents and five children. We reviewed 82 individual care plans for children, risk assessments and a variety of team specific and service based documents and plans.

Our inspection team

Team Leader: James Mullins Head of Hospital Inspections, Care Quality Commission.

The team included CQC Inspection Manager, a specialist advisor in paediatrics and child health, general nurse, health visitor and public health, a specialised paediatric physiotherapist and consultant paediatric nurse in palliative care.

Why we carried out this inspection

We inspected the core service as part of a comprehensive inspection of Black Country Partnership NHS Foundation Trust.

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?

For example:

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 16-20 November 2015. During the visit we held focus groups with a range of staff who worked within the service, such as managers, nurses, health visitors and therapists. We talked with people who used services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider say

Children, young people and their carers told us that they were treated with compassion, dignity and respect.

Feedback from a parent using the Family Nurse Partnership when talking about the family nurse who visited her included, “She is like a best friend, mother, counsellor and therapist, all rolled into one. Absolutely amazing.”

Feedback from a parent whose child was being cared for by the Palliative Care See Saw Team stated that they would, “Rate the service 10 out of 10.”

Good practice

- Staff across all CYPF services were committed to empowering young people through providing them with appropriate information and support to enable them to make decisions around the care they received.
- The Health Visitor Inclusion team, Sea Saw Palliative Care team and Health Visitor Ladies Walk team worked above and beyond to provide child centred, flexible appointments and involved children, young people and family members in decision making where possible.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Ensure there are suitable numbers of qualified staff to meet the needs of children and families across all CYPF services.
- Ensure all equipment is serviced as per manufacturer’s service schedule.

Black Country Partnership 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 Children, Young People and Families (CYPF) service as requiring improvement for safe.

We saw risks in relation to staffing levels in the Health Visiting Team as only one Community Nursery Nurse and one Specialist Health Visitor had a caseload of 96 complex cases. Staff told us they were consistently working above their contracted hours and due to the staffing and capacity issues we were not assured that children and families were adequately identified, monitored and managed to protect them from abuse an avoidable harm.

Staff were aware of how to report incidents; however, they were unable to access the trust's electronic incident-reporting system consistently due to poor availability of remote IT systems.

Clinical equipment in patients' homes was not maintained according to the manufacturer's service schedule.

Although there was evidence of robust safeguarding procedures in place, not all staff had received appropriate safeguarding children and adults training.

We also had some concerns around the management of paper records, where we observed them being transferred in an unsecure manner in a member of staff's handbag; we were told this was a method that was used often to transfer records and saw that this risk had not been identified on the service's risk register.

Incident reporting, learning and improvement

- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. At the time of inspection there were zero Never Events registered across community CYPF services.

Requires improvement

Are services safe?

- Between 1 September 2014 and 2 September 2015 there were 61 serious incidents reported by the trust via the National Reporting and Learning System. One incident related to community CYPF services. The incident related to a confidentiality breach within the School Nursing Service. We saw a full root cause analysis completed by the trust in which learning had been taken from the incident and an action plan to address areas of concern had been produced.
- Within a 12 month period 2014 to 2015 there were 251 incidents reported by staff across Community CYPF services. Six were administration of medication errors and 18 were falls. The majority of incidents concerned records, communication and patient information.
- We spoke with staff across CYPF services who told us that they were encouraged to report incidents and were aware of the need to do so. Staff also told us they were unable to access the trust's electronic incident-reporting system consistently due to poor availability of remote IT systems. We saw poor availability of access to the trust's IT systems for community based staff in CYPF services. We saw that the CYPF service have reported the inadequate IT infrastructure as a risk.
- Staff told us that they were made aware of trust wide incidents in various forms, for example, through weekly team meetings, monthly governance meetings and emails from line managers to share lessons learned. We saw evidence in the form of meeting minutes of incidents and actions being discussed at the monthly Children, Young People and Families Quality and Safety Group.

Duty of Candour

- During focus groups and interviews with staff, not all staff were aware of the duty of candour regulations 2014. Staff told us that they had received no formal duty of candour training; however, the trust had a Complaints Procedure in place in which the duty of candour was briefly described. In addition, we saw that the trust's electronic incident reporting system included a dedicated section for recording whether an incident was subject to duty of candour. Although staff were not aware of the Duty of Candour Regulations, they were able to describe the principles in practice. We saw that the trust had implemented a project entitled, "Freedom to Speak Up," to help further embed these principles.

Safeguarding

- We spoke to senior safeguarding staff including the Associate Director for Safeguarding and Head of Safeguarding Children. The senior staff described the safeguarding structure for CYPF services and we saw that the structure included 3 named nurses for safeguarding children, a lead nurse for domestic abuse, designated nurse for looked after children, lead nurse for child death reviews and a specialist nurse for looked after children reporting to the Head of Safeguarding Children. At the time of inspection, there was a vacancy within the trust's safeguarding structure for a Paediatric Liaison Nurse.
- Senior staff told us that a gap analysis review carried out in 2014 had identified the need for an integrated safeguarding process to be implemented across the trust. We saw a strong safeguarding structure had been put in place as a result of the review which clearly showed the reporting routes for both children's and adult's services, including names and contact details for leads across the trust. The safeguarding reporting structure was seen to enable reporting to executive level.
- Staff demonstrated a good knowledge of the trust's safeguarding policy and the processes involved for raising an alert.
- In a 12 month period between 2014 and 2015 there had been 50 safeguarding concerns reported by staff in community CYPF services on the trust's electronic incident reporting system. Six, concerns were classified as moderately severe, 33 were classified as low or no harm and 11 had no severity classification recorded.
- Staff told us and we saw that learning from safeguarding concerns was shared in a variety of formats including discussions at team meetings and via email. We saw a quarterly newsletter dedicated to safeguarding children in which developments in safeguarding learning, training, documentation and trust wide safeguarding contact details were included. Staff confirmed that this was received electronically on a quarterly basis.
- Data provided by the trust up to 04 December 2015 showed that for eligible staff, 98% had completed safeguarding children level 1 training, 98% had

completed level 2 training and 98% had completed level 3 training. The trust targets for completion of safeguarding children level 1 training was 95%; level 2 training was 85% and level 3 training was 85%.

- Safeguarding adults training is included in the mandatory training for community CYPF staff. Data provided by the trust up to 04 December 2015 showed that 98% of eligible staff had completed safeguarding adults level 1 training and that 85% had completed safeguarding adults level 2 training. The trust targets for safeguarding adults training of 95% and 85% respectively had been met.
- Through inclusion in the Safeguarding Children training CYPF services were aware of child sexual exploitation and female genital mutilation. Safeguarding referrals fed into 'MASH' (Multi Agency Safeguarding Hub) where they were reviewed by health, domestic abuse advisors, police, mental health services and the local authority.
- There was evidence of robust safeguarding procedures in place to protect vulnerable children; safeguarding alerts were investigated with a multi-disciplinary, multi-agency approach with trust wide governance support and review. Local and serious case reviews were held in a timely manner and we saw action plans supporting these reviews.
- In the Health Visiting Family Team, we observed a staff member make an immediate safeguarding referral for a child in need.
- We saw good peer review between Health Visitors to prevent safeguarding events from occurring through identifying areas of safeguarding risk. We saw implementation of early interventional strategies to reduce risk, particularly for those patients being cared for on the antenatal pathway.
- Staff within the Family Nurse Partnership Service told us that they were fully aware of the safeguarding aspects of their role and knew who the main point of contact was for raising safeguarding concerns. Staff also told us that they felt fully supported by management should they need to raise a safeguarding concern.
- Staff told us and we saw both routine and urgent safeguarding multi-agency planning meetings took place. Multi-agency professionals such as, teachers, police, social workers and healthcare professionals attended these meetings. Individual cases were reviewed, risks identified, care plans agreed and actions plans put in place to protect the child and support the family.
- During a records review we observed records that were not clearly identifiable as safeguarding records. The staff member was aware of the status of the record; however, this status would have been unknown to a new staff member due to a lack of an identifiable marking system.

Medicines

- The trust had a medicines management policy in place. Staff were aware of the policy and how to access it by logging onto the trust's intranet site and searching the A-Z policy list. The medicines management policy was seen to have been ratified in November 2015 with a review date of November 2018.
- The community pharmacist provided prescribing and dispensing of medication to children with complex needs in the community. The community pharmacist ensured children's medication was available and supported the children's community nurses with advice and support when required.

Environment and equipment

- We looked at the storage, maintenance and availability of equipment used in clinics, schools and equipment used by staff in children's own homes and we were told by staff that the servicing of equipment was not consistently up to date for CYPF services across the trust. For example, we were told by a physiotherapist that the Paediatric Physiotherapy service held 979 items of equipment in patients' homes within the Dudley borough and that approximately 50% of this equipment had not received a service within the recommended manufacturer timescale. We saw that the service contract is held by another NHS trust and staff told us that there is a dispute as to which equipment items should be included within the service contract. We saw that a risk assessment had been completed by the Physiotherapy Service Lead and escalated to senior management. We saw that a business case including an options appraisal had been provided to the Medical Devices Manager in April 2015, however, at the time of inspection, no further progress had been made and no action had been taken to address the issue.

Requires improvement

Are services safe?

- We reviewed the equipment log for the Palliative Care See-Saw Team for clinical electrical equipment within children's homes on long term loan. We saw that all of the equipment had current electrical testing certificates. We spoke to the team responsible for this who were very responsive to the team's needs and concerns, servicing and replacing equipment in a child's home as required.
- We saw committee meeting minutes in which the adaptation of the environmental audit (PLACE Audit) was discussed and agreed to be implemented for community CYPF services.

Quality of records

- The trust had a comprehensive Health Records Policy with additional standard operational procedures for transportation, creation, tracking and retrieval, missing records and retention and destruction of health records.
- We looked at the management of children's records across CYPF services and looked at 82 records in total. We saw records were maintained well, although there were some areas of concern with paper records. For example, In the Paediatric Speech and Language Therapy Service we observed paper records being transferred in an unsecure manner in a therapist's handbag between the main office base and children's schools. Staff told us that there would be approximately six records per staff member transferred in this method each day. We saw that this risk was not recorded on the service's risk register.
- We reviewed paper records in the Haemoglobinopathy Service and found that all records were well written with legible entries that were signed and dated, with the exception of one record that had gaps in the written notes. All records reviewed for the service had completed home visit risk assessments, assessment tools, abbreviation lists and copies of care plans included. The records contained shared information between other services.
- We saw service specific record keeping audits in which good practice was highlighted. We also saw areas requiring improvement as a result of the audits, such as, gaps in written notes, unwritten review dates and loose documentation within records being clearly noted and shared via the audit report.
- We reviewed advanced care plans (ACPs) in the Palliative Care See-Saw team. The ACP used within the team is implemented in services across the Midlands ensuring that wherever the child presents, the record is recognised and accepted. All ACPs reviewed were found to be comprehensive and adhered to the Health Records Policy with dated and signed entries.
- There was evidence of written consent and family involvement in records as well as records demonstrating care continuity and multidisciplinary approach to the care delivered.

Cleanliness, infection control and hygiene

- We observed inconsistency in infection prevention and control. We saw clinical areas at assessment clinics and health centres maintained cleaning logs for furnishings and toys, and found them to be satisfactory. We observed changing mats and scales being cleaned between each patient at baby clinics. We also observed Health Visitors not cleaning scales or toys between children and a lack of cleaning schedules within this service.
- Patients told us and we saw staff washing their hands and using hand gel in between each intervention.
- Community CYPF services participated in monthly hand hygiene audits. We saw evidence of issues highlighted during hand hygiene audits being escalated to the trust's Infection Control Committee with actions being implemented to address any issues.
- Infection prevention and control audits were performed on a quarterly basis for all community CYPF services. We saw that the results for quarter two, July 2015 to September 2015 were 100% for the majority of community CYPF services. We saw that in quarter two, the Health visiting Stourbridge team achieved 92% and the Paediatric Occupational Therapy and Physiotherapy services achieved 91%.
- Staff adhered to the trusts Infection Prevention Control policy, staff were bare below the elbows, and had access to personal protective equipment (PPE) if required.
- Signs were displayed around clinical areas reminding staff and visitors to wash their hands. Foot operated waste bins were available and in good working order.

Requires improvement

Are services safe?

- Community CYPF services had infection prevention champions who attended infection control meetings. The champions shared any actions to local teams to improve infection control practices.
- We saw evidence that named lead nurses within community CYPF services attended the trust wide Infection Control Committee meetings in which best practice and lessons learned were discussed. We also saw that actions to address any infection control issues were discussed and their progress recorded at the meetings.

Mandatory training

- The trust has nine mandatory training courses for community CYPF services including an annual mandatory training day, conflict resolution, patient moving and handling, paediatric basic life support, promoting safe and therapeutic services (PSTS), safeguarding adults and safeguarding children.
- The trust has a target completion rate for all courses of 95%. For safeguarding training for both adults and children, the trust intends to meet this target by December 2015.
- At the time of inspection, we saw from data provided by the trust that 92% of eligible staff across community CYPF services had completed the annual mandatory training day. 88% of eligible staff had completed conflict resolution training. 82% had completed moving and handling patient handling. 71% had completed paediatric basic life support. 81% had completed PSTS. 88% had completed safeguarding children level two and 93% had completed safeguarding children level three.
- Staff told us they were supported to attend mandatory training. We saw that all staff held, "Mandatory Training Passports," which enabled the tracking of training they had completed and that which was outstanding.

Assessing and responding to patient risk

- A range of risk assessments were implemented locally within services. For example in Health Visiting, a risk assessment had been completed in relation to lone working. We saw that measures had been put in place to reduce the risk of lone working such as logbooks in bases for health visitors to record their appointments, in addition to this; we saw mobile phones with a tracking application installed being held by health visitors in order that their location could be traced.
- In the Palliative Care See-Saw Team, we saw risk assessments held within patients' notes. The risk assessments seen were robust, current and seen to be updated as required and included MUST malnutrition and feeding assessments.
- Where risks were identified at a local level, staff were seen to have access to support, guidance and equipment to help manage risks.

Staffing levels and caseload

- There were significant risks to children and their families in the Health Visiting team due to the service being understaffed. The team consisted of one full time Specialist Health Visitor, one Community Nursery Nurse working 0.8 whole time equivalent (WTE) hours and 0.1 WTE administrative support. The team originally had 25 complex cases; we saw that this had increased to 96 complex cases within 12 months. The caseload consisted of child protection cases, children in need and early help intervention. We saw that the team were instrumental in protecting children at risk from female genital mutilation. We also observed support being provided to a parent to assist with reporting a family member to police. Staff told us that they are consistently working above their contracted hours to ensure that they are able to visit the most high risk children and families. Due to staffing and capacity issues, we were not assured that children and families were adequately identified, monitored and managed to protect them from abuse and avoidable harm. We saw that the service had not recorded this as a risk on their service specific risk register.
- We fed back our concerns to the trust during the inspection in relation to staffing levels within the Health Visiting Team. The trust advised that additional staffing cover would be provided within the service from 23 November 2015. We returned to the service unannounced on 3 December 2015 and found that no additional staffing cover had been implemented. When

speaking to the staff member during our unannounced visit, they told us that an initial meeting had taken place with the CYPF General Manager; however, no further progress had been made to commence staff in post.

- Trust provided data showed substantive staffing levels and vacancy rates for community CYPF services were as follows; Brierley Hill & Kingswinford Health Visiting (HV) team had 18 substantive staff with a 15% vacancy rate. Dudley Central HV team had 19 substantive staff with a 4.5% vacancy rate. Dudley North HV team had 13 substantive staff with a 5.7% vacancy rate. Halesowen HV team had 13 substantive staff. Stourbridge HV team had 14 substantive staff. Child Development Unit had 5 substantive staff with a 27.3% vacancy rate. Childrens Management had 8 substantive staff with a 44.8% vacancy rate. Childrens Palliative Care had 10 substantive staff with a 8.5% vacancy rate. Haemoglobinopathies Service had 2 substantive staff. Family nurse Partnership had 8 substantive staff with a 2.4% vacancy rate.
- Staff told us and we saw that the Paediatric Physiotherapy Service receive approximately 20 musculoskeletal (MSK) paediatric referrals per month. Staff told us that due to capacity they were unable to provide care to all who were referred and as such referred children they were unable to see to the adult MSK service. We saw that the adult physiotherapy team is not sufficiently skilled or trained to assess or treat children with MSK needs. We saw that a draft business case had been created to propose additional staffing for the Paediatric Physiotherapy service to undertake these referrals and negate the need to refer children to adult services.
- The Family Nurse Partnership (FNP) had an expected caseload of 162 clients. We saw that at the time of inspection, there were 134 people enrolled in the FNP, 16 were in the process of being enrolled onto the programme and an additional 27 had recently graduated from the programme. We saw that the expected caseload is in line with the FNP Advisory Board recommendation of 23 to 25 clients per FNP Nurse. Staff told us that the recruitment of two additional nurses to the team would bring the expected caseload to 184 clients by April 2016.
- Trust induction attendance for new starters was 100% for all community CYPF services.
- Data provided by the trust showed an average staff sickness rate of 3.3% across all community CYPF services. We saw that Dudley North Health Visiting Team was an outlier with a staff sickness rate of 16.6%. The Trust wide sickness rate was seen to be 5.4%.

Managing anticipated risks

- There was a dedicated risk register for community CYPF services.
- We saw documentary evidence of risks recorded on the risk register being escalated to and discussed at the CYPF Quality and Safety Steering group.
- At the time of inspection, there were 26 open risks for CYPF. 19 were classified as moderate level and seven were classified as low-level risks.
- At 13 October 2015, there were four risks for CYPF that were overdue review. The risks related to:

- Estates support and infrastructure (Risk 321)

- Inadequate IT Infrastructure (Risk 352)

- Eating Disorder Service Wolverhampton (Risk 378)

- Lack of clarity regarding children subject to child protection plans (Risk 410)

- For Paediatric Physiotherapy we saw that a risk had been closed relating to a lack of administrative support for the service. The trust had addressed the risk through allocating additional administrative support to the service.

Major incident awareness and training

- The trust had a major incident and business continuity plan in place that was overseen by the trust's Business Continuity and Emergency Preparedness Group.
- We saw that major incident and business continuity training was discussed at trust Board level and that the trust had identified the training needs for all staff that had a role in the business continuity plan.

Good

Are services effective?

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

Summary

The effectiveness of CYPF services was good.

Evidence based practice was delivered across all community CYPF services and that national programmes of care were followed.

We saw competency based training programmes within each community CYPF service.

We saw evidence that patient needs were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant that children and young people received the care and treatment they needed.

We saw that IT systems were not fully integrated across community CYPF services.

Evidence based care and treatment

- All community CYPF services delivered evidence-based practice and followed recognised and approved national guidance in accordance with their governing bodies. This included the NMC (Nursing and Midwifery Council), the RCPCH (Royal College of Paediatrics and Child Health), the NICE (National Institute for Clinical Excellence) and the HCPC (Health and Care Professional Council).
- The organisation followed the national initiative called the healthy child programme. This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children. It offers regular contact with every family and includes a programme of screening tests, immunisations and vaccinations, development reviews and information, guidance and support for parents
- The Family Nurse Partnership service provided evidence based, preventative support for vulnerable first time young mothers, from pregnancy to until the child is two years of age. Family nurses delivered the programme, within a defined and structured service model. We saw that the service adhered to NICE clinical guidelines appropriate to the service including, guideline 62 Antenatal Care and guideline 37 Postnatal Care. We saw evidence based assessment tools in use including Ages and Stages questionnaires and the Hospital Anxiety Depression Scale.
- We saw evidence of local audits being completed within community CYPF teams and saw evidence that learning was discussed at team meetings.

Pain relief

- There were clear guidelines for staff to follow which reflected national guidance.
- Care and treatment was planned and delivered to meet the pain relief needs of children. We carried out a review of records in the Palliative Care See Saw Team and saw that care plans were up to date, reviewed regularly and were reflective of the child's changing pain relief needs. We saw the majority of pain relief for children at home was administered by their parent, who received training, guidance and support from the children's nurses.

Nutrition and hydration

- Care and treatment was planned and delivered to meet the nutrition and hydration needs of children. Where appropriate, children had a nutritional and hydration plan in place that reflected national guidance and demonstrated a multidisciplinary approach to meeting children's dietary needs.
- During our inspection, we saw that staff gave parents up to date and relevant advice about nutrition and hydration in children. For example, in the Speech and Language Therapy Service we saw a Therapist provide clear explanations, advice and information to a parent in relation to post-operative feeding of their child. The Therapist was seen to undertake detailed questioning in a calm and reassuring manner. The Therapist was seen to perform a swallowing assessment and provided an explanation of the assessment to the parent. We saw the Therapist both provide advice and demonstrate the appropriate feeding technique to the parent.

Technology and telemedicine

Good

Are services effective?

- In the services we inspected we did not observe the use of telemedicine.

Patient outcomes

- We saw that community CYPF services completed audits to measure quality of patient outcomes.
- We saw that community CYPF services participated in the Healthy Child Programme. Health Visitors had key performance indicators (KPIs) aligned to the contact stages in the programme.
- For quarter two 2015 we saw that primary new birth visits completed within 10-14 days had a completion rate of 95.4%. Visits completed after 14 days had a completion rate of 98.7%.
- We saw that for quarter two 2015 the six to eight week review visit had a completion rate of 98.4%. The nine to twelve month development check had a completion rate of 95.7% at twelve months and 98% at 15 months. The 2 to 2.5 year development check had a completion rate of 95.3%.
- The Health Visiting Team's immunisation programme for immunisations between 1 November 2014 and 31 October 2015 had the following outcomes; The immunisation programme for children completing a course of immunisations before their first birthday had an average of 96% completion rate, in addition14.4% of children received the BCG immunisation before their first birthday. The immunisation programme for children completing a course of immunisations before their second birthday had an average of 96% completion rate. For children completing a course of immunisations before their fifth birthday there was an average of 95% completion rate.
- We saw that exception reporting took place against the health visiting KPIs. It was seen that the majority of reasons for an uncompleted visit was recorded as being a did not attend (DNA) appointment.
- We saw evidence that patient needs were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant that children and young people received the care and treatment they needed.

Competent staff

- Staff across community CYPF services demonstrated they possessed sufficient knowledge, and were competent to deliver care and treatment to children and their families.
- We saw that services across the trust had competencies based training in place. Competencies for which training was provided varied between services, however was seen to be appropriate for each staff role and grade.
- For example in the Palliative Care See Saw Team, we saw that staff were provided with a training manual that covered 24 core interventions including nasogastric tube awareness, tracheostomy and central line competencies. We saw that the competencies were reviewed on a yearly basis and that staff were able to undergo any additional service specific training required to meet the competencies.
- The Health visiting teams received training in sexual exploitation and female genital mutilation as an integral part of safeguarding level 2 training.
- The Therapy team received training with long term conditions, such as respiratory conditions and also , mobility and motor skills.
- Staff told us that they were able to raise additional training requests at their appraisal meetings; however, community CYPF staff we spoke to told us that they felt that trust provided training was predominantly focused around mental health training requirements.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary working across all community CYPF services was robust proactive and planned in advance.
- On a school visit we saw a nurse teaching carers the correct procedures for giving oral suction and changing of tracheostomy tubes. The teaching and support provided to the school staff acting as carers, enabled the children to remain in school. We observed that the time spent by the nurse was a real investment in both the wellbeing of the children and in building good multi-disciplinary working relationships with the school staff.
- We saw effective multi-disciplinary team working at a baby group. This was a joint meeting involving an occupational therapist, physiotherapist and the child's parent. We saw that there was parental involvement in

the session and that the staff interacted appropriately with both the parent and child. We saw staff demonstrating activities on a one to one basis with the child whilst providing clear instructions throughout to both the child and the parents. We saw a clear discussion by both staff with the parent in relation to the child's progress.

- We saw actions in place for a child's care plan to be produced jointly between for a child who was due to commence nursery. We saw that a meeting was scheduled to produce the care plan between the physiotherapist, the nursery and the parents.
- The Palliative Care See Saw Team were an integral part of the West Midlands Palliative Care Network; the team used the network to support their practice and to assist in the development of their policies and standard operational procedures.
- We saw a multi-disciplinary meeting between a speech and language therapist, a team lead for the service, a consultant paediatrician and a parent. We saw advice in relation to communication strategies to meet the needs of the child being discussed and saw the information being provided to the parent who was present in a clear and effective manner.
- There was good multiagency working between health visitors, public health staff and a children's centre in relation to the Integrated Target Intervention programme that targeted childhood obesity.
- In the Health Visiting Family Inclusion team we observed strong partnership working with social services and the arrangement for a joint visit with the Health Visitor and Social Worker to take place.
- Coordinated care pathways were in place in community CYPF services, for example, we saw a joint motor coordination pathway in use between children's occupational therapists and physiotherapists.

Referral, transfer, discharge and transition

- Referral arrangements were in place for children and young people transferring between services. We saw that comprehensive care packages were put in to place in a timely manner for patients transitioning to adult services.
- In the Palliative care See Saw Team we saw an ACP for a young person who was transitioning to adult services. The team had ensured that the ACP was converted to the adult documentation and the needs of the young person were accurately updated and transcribed.
- Staff told us of their concerns surrounding handover between children's community nursing employed by a neighbouring trust providing short-term interventions and the Palliative Care See Saw Team.
- Staff told us that they were not always informed by the community nurses of when a child was being discharged from the early intervention service provided by the neighbouring trust. We were told work was underway to try to improve communication between neighbouring trusts.

Access to information

- Staff told us and we saw that there were numerous IT systems in use across the trust. We saw that the IT systems were not integrated across community CYPF services. Access to the IT systems and the effectiveness of their use varied in consistency between services.
- In the Family Nurse Partnership service we saw the Open Exeter IT system in use to enable secure information sharing between health care professionals. Staff within the service told us and we saw the system being used for recording visit details and inputting and accessing national information.
- In the Haemoglobinopathy Service access to blood results was not possible during clinics being held at Russells Hall Hospital due to the staff member being unable to log in to the system at the clinic. A staff member told us that they accessed the results prior to the clinic when they were at their base location, however the system was not updated regularly and therefore the results being accessed were not up to date when the clinic took place.
- In the Speech and Language Therapy Service there was no remote access to IT systems and we saw that staff were required to travel back to their base location in order to access the trust's IT systems.
- We spoke to 20 parents and carers who told us that they received information from staff in relation to treatment strategies and that they received good communication from staff members.

Good

Are services effective?

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Across CYP services we saw that staff gained consent before each intervention and parents told us they were asked for verbal consent and sometimes written consent depending on what the treatment of care was.
- Consent was recorded in school records and included in care pathways and documentation.
- To assess whether a child was mature enough to make their own decisions and give consent staff used agreed processes and frameworks, including 'Gillick competencies' and 'Fraser guidelines'.
- Staff told us that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was included within the e Safeguarding Adults Level 2 Training, however, at the time of inspection, we saw that specific MCA and DoLS training had not been implemented.

Outstanding ☆

Are services caring?

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

Summary

Community CYPF services were rated as outstanding for 'caring'.

The feedback we received for the CYP community teams was excellent. Children, parents and carers were continually positive about the care that was provided and the way that staff treated them. People told us that they felt that staff went the extra mile when they provided care.

Staff were committed to empowering young people through providing them with appropriate information and support to enable them to make decisions around the care they received.

Children, young people and their carers told us that they were treated with compassion, dignity and respect. They were involved in discussions about treatment and care options and able to make decisions. Information was provided in a number of formats to enable young people to understand the care available to them and help them to make decisions about the care they wanted to receive.

We saw numerous examples of staff going beyond the remits of their role to overcome obstacles to ensure the needs of the child, family and carers were met.

Compassionate Care

- Children's and young people's assessments and treatments across community CYPF services were carried out at appropriate stages of their development and at significant times of their lives within each service and between services. For example, the Family Nurse Partnership (FNP) service invited young expectant mothers up to the ages of 19 years onto the programme and supported them when the child was born and until two years of age. We observed a FNP home visit in which we saw excellent caring and compassionate interaction between the FNP nurse, client and baby. We saw the FNP nurse provide support to the young mother who was in a wheelchair, the nurse was seen to perform appropriate child safety and environmental risk assessments, working with the young mother to enable her to continue to care for her baby. The young mother fed back to the inspection team that she felt supported by the FNP team and stated that she felt, "The family Nurses believe in me and that every young person should be part of the programme."
- Interactions we observed across all community CYPF services were undertaken in a dignified and compassionate way. A mother told us how the Health Visiting Family Inclusion Team had supported her when required. The mother told us that she felt that she had been, "Supported all the way," by the Family Inclusion Team. We saw staff approached the care of children and their families with professionalism and genuine compassion.
- Patients were treated as individuals and we saw that staff and patients had built up excellent working relationships and had a natural rapport with children and families. As well as children, we talked to 20 parents who told us they were always treated with dignity and respect.
- During home visits and interactions between staff at clinics and schools we saw staff helped children and their families understand the care treatment and care support available to them. For example in the Children's Assessment Unit we observed caring interactions between clinicians and parents with clinicians providing clear feedback and answering any questions from parents following their child's diagnosis.

Understanding and involvement of patients and those close to them

- Support for children across community CYPF services was child centred and we saw children and parents were fully involved in decision making, treatments and options available to them.
- Parents and carers of children told us that staff focussed on the needs of them and their children and that they felt involved in discussions about care and treatment options. We saw a mother diagnosed with bipolar disorder wished to breastfeed her child, and was being supported and supervised medically to reduce her medication in agreement with the doctor in order to enable her to commence with breastfeeding.

Outstanding ☆

Are services caring?

- We saw health visitor staff jointly reviewed children's' developmental milestones in partnership with parents using validated evidence based tools the 'Ages and Stages' questionnaire (ASQ). Parent's opinions and views were sought and fully involved in their child's development review.
- Across children's centres, baby clinics, mainstream and special schools we saw information leaflets and booklets available for parents that included clinic times, support networks, self-help group and contact details.
- Information leaflets were available in many formats including pictorial and simple text.
- We saw that community CYPF services also provided information leaflets on topics not directly related to their service. For example, we saw an advice leaflet providing information and contact details for the local Citizen's Advice Bureau (CAB). The leaflet explained the services that the CAB were able to offer and addressed areas such as money worries, benefits advice, employment and housing issues and family issues. The leaflet was targeted towards families with children and was seen to include appropriate contact details.

Emotional support

- We saw many examples of emotional support being given to children and their parents during the inspection. For example, the Palliative Care See Saw Team went above and beyond the remit of their role to care for a young person and their parent. The team organised to take the young person on a day trip outing where they arranged for activities and lunch to be provided. The team had recognised that the parent was under significant emotional pressure. Through arranging the day trip for the young person the team were able to provide some respite to the parent.
- We saw staff in the Health Visiting Family Inclusion Team go above and beyond the remit of their role to provide support to the pregnant mother of a large family. We saw the Health Visiting Family Inclusion Nurse collect food from a local food bank and then visit a superstore to pay for nappies and formula baby milk using their own money to do so. The Family Inclusion Nurse then returned to the mother to deliver the food and baby produce. Our inspection team felt through doing this the staff member showed significant compassion and emotional support to the mother in need.
- We saw the Local Safeguarding Children's Board (LSCB) had commended the Palliative Care See Saw Team following a child death review panel. The LSCB stated that the See Saw Team had provided professional and compassionate care, going above and beyond requirements in the child's case prior to their death.

Good

Are services responsive to people's needs?

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

We found this domain to be good overall.

Services were tailored to the needs of local populations and most staff were able to access training specific to the needs of the populations they supported. There was access to interpreters for all community CYPF staff.

Care was provided from a number of settings to increase the accessibility of the service being provided.

Services offered flexible appointments to meet people's needs. The Haemoglobinopathy Service offered appointments outside of school times to minimise disruption to childrens education. Health Visiting teams ran evening clinics to allow the service to be accessed by working parents.

Planning and delivering services which meet people's needs

- Community CYPF services planned and delivered care to meet the needs of the child/young person and their parents. Care was well organised and managed keeping the child at the centre of treatment and care.
- Health Visitor teams provided care from various settings, for example, children's centres, baby clinics and children's own homes and special schools in order that parents had a choice of options available for accessing the service.
- We saw flexible appointments being offered by community CYPF services. For example, we saw that the Haemoglobinopathy Service offered appointments outside of school times. This enabled the child to access the service with minimum disruption to their education.
- The Health Visiting team based at Ladies Walk Centre had implemented a monthly clinic running between five and seven in the evening. The amended opening hours enabled the clinic to be accessed by working parents. We saw that this was the best attended health visiting clinic across the trust and staff told us that because of its success, additional evening clinics in other localities were planned to be implemented.
- The Paediatric Physiotherapy Service had been redesigned so that the service was not only provided within a child's school but also within an outpatient clinic held at the Sunflower Centre. The redesign helped to increase the level of engagement with parents whose children were using the service.

Equality and diversity

- Staff told us and we saw that all community CYPF staff had access to interpreters and that they were widely used to ensure that effective communication took place between staff, patients, families and carers.
- We saw Health Visiting staff book interpreters in advance in order that there were no delays in communication during home visits and clinics.
- Equality and diversity training was included within the trust's annual mandatory training programme as well as within the trust induction. We saw that community CYPF services had an average completion rate for mandatory training of 91%. We saw that the attendance rate for trust induction across community CYPF services was 100%.

Meeting the needs of people in vulnerable circumstances

- We saw therapy teams working together to meet the needs of vulnerable children for example we saw joint working between occupational therapist and physiotherapists to enable children to attend a single appointment.
- We saw therapy teams working together in special schools to meet the needs of vulnerable children through specialist pathways, for example, autism spectrum disorder, cerebral palsy, muscular dystrophy and speech difficulties.
- We saw good daily activity planning in the Palliative Care See Saw Team, workload was scheduled and documented in a rota system, enabling staff to ensure that the most vulnerable children were prioritised and seen in a timely manner.
- The Health Visiting Family Inclusion Team responded immediately to meet the complex needs of families. The team carried out assessments usually within the same

Good

Are services responsive to people's needs?

day and ensured that the team acted quickly when referring to external agencies such as the local authority, police and general practitioners in relation to safeguarding concerns.

Access to the right care at the right time

- Assessments for children and young people took place at appropriate times across all community CYPF services. For example, we saw how the key contact stages within the Healthy Child Programme were included within the community CYPF services key performance indicators.
- The Paediatric Occupational Therapy Service had an average of 12 weeks from referral to treatment which was within the national target of 18 weeks, Paediatric Physiotherapy however, had an average referral time of 20 weeks from referral to treatment which was below the national target of 18 weeks for non-urgent cases, Speech and Language Therapy Services were below the national target for referral to initial assessment for all areas except the services offered to school age children in which the target was exceed by an average of two weeks,
- There were many examples of multiagency and multidisciplinary working to make sure that patients were able to access all of the services they needed.
- The Haemoglobinopathy Service used a "traffic light," prioritisation system for home visits. We saw that the system enabled the specialist nurse to determine the appropriate timescales between visits for patients post discharge, in managed sickle cell crisis and those who were clinically stable.
- In the Palliative Care See Saw Team we saw a childrens nurse arrange a visit to a child attending main stream school to change their tracheotomy tube. We observed this procedure was carried out in the school class room at break time. The procedure was quick and we were told less stressful for the child and avoided the need for the child to go to hospital. This enabled the child to access care in an environment and at a time to suit them.

Learning from complaints and concerns

- Staff we talked to were aware of and knew how to access the trusts complaints policy.
- We saw PALS (patient advice and liaison service) posters were displayed in clinics, children centres and schools.
- From May 2015 to October 2015 there had been two complaints reported. The complaints related to Health Visiting (Brierley Hill and Kingswinford) and Paediatric Physiotherapy.
- Staff were aware of how to resolve complaints locally and when to escalate to senior management. The trust had a complaints policy that staff adhered to.
- Staff told us and we saw that complaints and concerns were discussed at team meetings and that learning was shared locally at the team meetings. We saw that complaints across CYPF services and lessons learnt were discussed at the CYPF Quality and Safety Steering Group.

Requires improvement

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 the well-led domain as requires improvement.

Senior managers had not supported the Health Visiting team with additional resources to manage a case load that had quadrupled in size over the last 12 months. Staff were struggling to cope daily and we were not assured children and families were protected against abuse and avoidable harm. Senior managers were aware of the significant issues threatening delivery of safe and effective care.

We were told by a senior physiotherapist that the Paediatric Physiotherapy service held 979 items of equipment in patients' homes within the Dudley borough and approximately 50% of this equipment had not been serviced within the recommended manufacturer timescale.

We saw a disconnect between the senior management team and staff within community CYPF services.

There were delays in implementing actions when risks and concerns had been escalated to senior management.

We saw strong local leadership with the majority of staff we spoke to telling us that they felt supported by their direct line manager, but less so from senior managers or the executive team.

Service vision and strategy

- We asked staff and team leaders if they were aware of the trust's strategy for community CYPF services. Staff told us that they were aware of local strategies in place; however felt that they were not receiving adequate communication from senior management in relation to the trust wide strategy for the service.
- Staff within the Children's Speech and Language Therapy Service told us that they were uncertain of the future for the service. Staff within Palliative care See Saw Team also told us that they were unsure as to the direction the service would take in future.
- Staff from all disciplines described themselves as 'happy' to work within their respective teams and were proud of the care and treatment they provided to children young people and families. This was displayed by all staff we talked to individually and in staff focus groups.
- Staff told us that recruitment to vacant positions was challenging due to delays encountered within the recruitment process

Governance, risk management and quality measurement

- Within the Health Visiting Team, the specialist Health Visitor was unsupported and managed a caseload that had quadrupled in size form 25 cases to more than 100 cases within a 12 month period. We were told by senior managers that the service should have submitted a business case to request more staff; however the service lead was given no support to write it. Senior managers were aware of the complexities of the cases and the risks related to understaffing but had not addressed the issue and was unsupportive to the team.
- We saw both members of the team had worked in excess of an extra seven hours per week to try and manage the case load.
- We saw incidents had not been reported via the electronic record system, we were told this was due to lack of capacity within the team to do so. We saw by not reporting incidents, senior managers were not aware of all the potential and actual risks which faced the team and lessons were not shared to improve practice.
- We provided detailed feedback to the trust during our inspection and we were assured the service would receive an additional full time Health Visitor on 23 November 2015t to assist with the caseload.
- During the unannounced visit to the service on 3 December 2015 we saw that no additional staff had been sent.
- We were sent an update from the senior manager following our unannounced visit to inform us additional staff would be sent to the service on 7 December 2015. However, we were not confident children and families

were protected against abuse and avoidable harm. On 9 December 2015 we made a statutory request for further information relating to this service in accordance with Section 64 of the Health and Social Care Act 2008.

- The Paediatric Physiotherapy service held 979 items of equipment in patients' homes within the Dudley borough and that approximately 50% of this equipment had not received a service within the recommended manufacturer timescale. We saw that the service contract was held by another NHS trust and staff told us that there was a dispute as to which equipment items should be included within the service contract. A risk assessment has been completed by the Physiotherapy Service Lead and escalated to senior management and a business case including an options appraisal has been provided to the Medical Devices Manager in April 2015. Following the unannounced visit to CYPF services on 3 December 2015 the trust sent us an update on the 4 December 2015 entitled 'Action Plan: Update from issues raised during CQC Inspection'. The update informed us of the trusts intentions to address the equipment problem. However, we saw there was no timescale for actions, no identified person responsible for carrying out the actions and no timescale for review. We saw senior management had taken no action to address this risk despite the options appraisal was submitted seven months previous. We were not assured patients had been protected against avoidable harm.
- The Paediatric Physiotherapy Team were providing care that was not included in the service level agreement with Dudley Group of Hospitals. For example, the team was contracted to provide neonatal and extended scope practitioner care for eight hours per week. The team provided over and above their contracted agreement on an ad-hoc basis when asked by consultant medical staff at the hospital to do so. The team leader was aware that the team was providing a service outside of its contractual agreements however continued to allow staff from the service to provide additional unfunded care. This additional service had the potential to impact on the capacity of the team to provide care to children and young people in other areas of the service such as special schools and musculoskeletal physiotherapy. This was not included on the service's risk register.
- Each individual community CYPF service held its own risk register. Staff told us that they felt able to record risks on the register; however, we saw risks surrounding staffing capacity that were not recorded. For example in the Health Visiting Team, the specialist nurse advised that they had raised a concern in relation to staffing with their line manager but this was not seen to have been recorded on the electronic incident reporting system.
- Staff told us that when risks and action plans had been escalated there were delays in actions being taken by the senior management team to address them. We saw that the Palliative Care See Saw Team had submitted an implementation plan to senior management. The team were continuing to await approval of the plan 16 months following submission, resulting in service specific policies and standard operational procedures remaining in draft format.
- Community CYPF services had appropriate key performance indicators that were used to measure both the performance of the service teams. We saw that these were reported both locally via team meetings and to executive level via the trust's committee structure. However, we saw a lack of patient outcome measures in use in occupational therapy, physiotherapy and health visiting services.
- We saw evidence of a clear reporting structure for safeguarding concerns across community CYPF services. Staff told us that they were aware e of the safeguarding reporting structure and knew the process they were required to follow in order to raise a concern.

Leadership of the service

- Leadership at a local level within community CYPF services was good. For example, a staff member in the Palliative Care See Saw Team told us, "It is the best team that I have worked in in 30 years of nursing." However, support from senior leaders was not in place.
- We were told there had been several temporary senior leaders across CYPF services, which had left staff unsettled and confused, due to conflicting priorities of different managers.
- Two new senior managers had joined CYPF services in August and September 2015 and were familiarising themselves with services.
- Despite, previous and multiple changes of managers, staff across all CYPF services were enthusiastic, motivated and felt supported by their local team leaders. We saw that team managers were very

Requires improvement

Are services well-led?

dedicated to their teams and worked very hard to lead by example, however we noted that some team managers were working above their contracted hours on a regular basis.

Culture within this service

- We found staff culture across community CYPF services was dedicated and compassionate, however was not seen to be strongly supported at group, directorate and executive level.
- Staff were hard working and committed to providing the best care possible to children young people and their families on a daily basis.
- Staff from all disciplines spoke with passion about their work.
- Staff told us that they felt that the community CYPF services were not fully integrated in the wider Mental Health trust.
- We saw lone working arrangements for health visitors were in place and implemented well at a local level. For example, we saw the use of a tracking application on health visitors' mobile phones in order that their location would be known.

Public engagement

- The trust took part in the friends and family test. A nation-wide initiative to help organisations to assess the quality of their services by asking people who used the service whether they would recommend the service.
- For the period June to September 2015 of 196 responses to the Friends and Family Test, 98.2% would recommend CYPF services to a family or friend. We saw that feedback from the questionnaire on what was good and suggestions for improvement is shared on a monthly basis with service teams across the CYPF group. We saw that an improvement plan had been developed for CYPF services to prioritise the monitoring of listening to and learning from service user feedback.
- Services gathered verbal and written feedback in the form of thank you letters and cards to evidence satisfaction across community CYPF services.

Staff engagement

- Staff told us that they felt engaged at a local level and we saw that there was frequent communication with them via team meetings and emails within their direct team.
- We saw that staff did not always feel engaged with senior management due to ongoing changes within the trust's senior management structure.
- Staff in community CYPF services told us that they did not feel fully integrated with the wider trust since the focus of their services was physical health whereas the majority of services provided by the trust were mental health services.

Innovation, improvement and sustainability

- New methodology was shared locally between trust services and with external organisations to help drive wider health improvements.
- Staff told us that they were encouraged to suggest ways to improve services, however found that if the initiative required additional resources there were often lengthy delays in approval and implementation of the initiative.
- We saw excellent local strategic leadership in relation to services for vulnerable children including robust procedures and pathways for looked after children and those children at risk of child sexual exploitation and female genital mutilation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) HSCA (RA) Regulations 2014 Staffing Levels** **There was not adequately qualified staff across all services to meet the needs of patients to protect them from abuse and avoidable harm.** **HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 18 (1)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 (1)(e) HSCA (RA) Regulations 2014 Premises and Equipment** **The trust did not ensure all equipment used in patient's homes were properly maintained and own homes were properly maintained and serviced as per manufacturers service schedule.** **HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 15 (1) (e)**