The Rotherham NHS Foundation Trust

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Community health services for children, young people and families

Quality Report

The Rotherham NHS Foundation Trust
Rotherham Hospital
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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)
RFRHC	Rotherham Community Health Centre	Children's teams	S60 1RY

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

Summary of findings

Ratings

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

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Overall summary

The Rotherham Hospitals NHS Foundation Trust provided a range of community health services for children, young people and families in the Rotherham area.

We inspected the following regulated activities that the trust is registered with CQC to provide:

- Diagnostic and screening procedures
- Family planning
- Treatment of disease, disorder or injury

During our inspection we spoke with 18 parents or carers, children and young people. We spoke with a range of staff, 46 in total, including health visitors, school nurses, community nurses, nursery nurses, doctors, therapists, and administration staff. We observed clinics with community paediatricians and therapy staff. We accompanied health visitors on home visits.

The systems in place for reporting and recording safety concerns, incidents and near misses were not used effectively or consistently. Staff did not always receive feedback about the action taken when they reported issues. There were gaps and inconsistencies in safeguarding systems and processes. Complete and robust information was not always available for multi-agency decisions about children at risk of abuse.

There were no appropriate arrangements in place for the safe management of medicines in the short break service. There were practices that put children using the short break service at increased risk of acquiring an infection.

Some key outcomes for children, young people and families using the service were regularly below expectations. Outcomes of care and treatment were not always consistently or robustly monitored.

Staff had the right qualifications, skills, knowledge and experience to do their job. However, staff were not always supported to have training to help them to develop additional skills and expertise. Staff working away from their office bases were hindered by old and ineffective IT equipment.

Care and treatment of children and young people was planned and delivered in line with current evidence based guidance, standards and best practice. Consent to care and treatment was generally obtained in line with relevant guidance and legislation. However, staff were not always aware of the need to obtain consent for sharing information.

There were examples of collaborative and effective multi-disciplinary and multi-agency working to meet the needs of children and young people using the service. However, this was not consistent in all areas of the service as there were some gaps and missed opportunities.

Feedback from those using the service was positive about how they were treated by staff and about how they were involved in making decisions with the support they needed.

Waiting time targets were not met for physiotherapy non-urgent appointments and child development centre appointments. This meant that children and young people were experiencing delays in receiving treatment and support for their health needs.

Other services were planned and delivered in a way that met the needs of the local population. Examples of these included the Family Nurse Partnership, the audiology service, and a health visitor service for children, young people and families who were asylum seekers.

The risks and issues described by staff did not always correspond to those reported to and understood by their leaders. Leaders in the service were not always clear about their roles and their accountability for quality. The need to develop leaders was not consistently identified and appropriate action was not always taken to support them.

Staff did not feel actively engaged or empowered. When staff raised concerns or ideas for improvement, they felt they were not always taken seriously.

There was an inconsistent approach to obtaining the views of children, young people and families using the service.

Summary of findings

Background to the service

Community health services were transferred from the Primary Care Trust to The Rotherham Hospitals NHS Foundation Trust on 1 April 2011. The trust delivered acute and community care to a local population of 257,600. Services were provided across Rotherham, plus some services in Barnsley and Doncaster.

Community health services for children, young people and families delivered by the trust included: child development assessment, physiotherapy, occupational therapy, speech and language therapy, contraception and sexual health services, Family Nurse Partnership, health visitors and school nurses. There were specialist services, such as those for children with autism, epilepsy or attention deficit hyperactivity disorder.

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Chair Thames Valley Clinical Senate

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included two CQC inspection managers, 12 CQC inspectors and a variety of specialists including: consultant surgeon, consultant in respiratory medicine, a consultant paediatrician, consultant intensivist, a GP, a student nurse, two midwives, two executive director nurses, a governance expert, an occupational therapist, a speech and language therapist, a matron, two community adult specialist nurses, one health visitor, one school nurse, a physiotherapist, a head of children's nursing and a dentist. We were also supported by two experts by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Before our inspection we reviewed a wide range of information about The Rotherham Hospital NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the Clinical Commissioning Group (CCG), NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

We held a listening event in Rotherham on 17 February 2015 where members of the public shared their views and experiences of the trust. Some people also shared their experiences of the trust with us by email and telephone.

The announced inspection Hospital took place between 23-26 February 2015. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

Summary of findings

We talked with patients and staff from all the ward areas, outpatient's services as well as in the community services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection on 7 March 2015 at Rotherham Hospital. The purpose of our unannounced inspection was to look at the children's ward and the medical assessment unit.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment delivered by the trust.

What people who use the provider say

We spoke with over 40 people who attended our listening event. Some people were very positive about the care they had received at the trust. Other people were less positive about their care.

The NHS Family and Friends (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The trusts performance in all of the NHS Friends and Family tests in January 2015 was largely positive.

- The trust scored higher than the England average of 96% for the inpatient FFT, with 98% of patients recommending the inpatient services provided by the trust. a total of 361 patients responded to this question.
- The trust scored slightly lower (worse) than the England average of 87% for the A&E FFT, with 73% of patients recommending the service. A total of 997 patients responded to this question.
- The trust scored higher (better) than the England average of 96% for the antenatal question in the maternity NHS FFT, with 100% of women recommending this service.
- The trust scored higher (better) than the England average of 97% for the birth question in the maternity NHS FFT, with 99% of women recommending this service.
- The trust scored higher (better) than the England average of 93% for the post natal ward question in the maternity NHS FFT, with 100% of women recommending this service.
- The trust scored higher (better) than the England average of 97% for the post natal care in the community question in the maternity NHS FFT, with 100% of women recommending this service.

From April 2014, the staff NHS Friends and Family Test (SFFT) was introduced to allow staff feedback on NHS services based on recent experiences to be captured. Staff were asked to respond to two questions. The "care" question asks how likely staff are to recommend the NHS service they work in to friends and family. The "work" question, asks how likely staff would be to recommend the NHS service they work in as a place to work.

The trusts scores in this test were lower (worse) than the England average. Fifty seven per-cent of staff would recommend the trust for care and 43% would recommend as a place to work. The England averages were 77% for the care question and 61% for the work question.

The trust had a total of 29 reviews during 2013-14 on the NHS Choices web site. Fifty nine per cent of these were positive and 41% negative. On the Patient Opinion website there were 133 reviews, of which 70% were positive and 30% negative. In February 2015, the Patient Choices website gave the trust an overall rating of 3.5 stars out of a possible five which meant patients had rated this hospital as they would be "likely to recommend" it.

The CQC Adult Inpatient Survey was carried out between September 2013 and January 2014. A total of 367 patients responded to the survey. The overall score for the trust was about the same as other trusts. There were ten areas of questioning in this survey and nine out of the two areas were about the same as other trusts, but the

Summary of findings

questions relating to the hospital and wards scored worse than other hospitals. This was due to the response to the questions relating to food quality, food choice and single sex accommodation.

In the Survey of Women's Experience of Maternity Care (CQC 2013), the trust performed about the same as other trusts in all of the four areas. The survey asked women a number of questions relating to their labour and birth, the staff who cared for them and the care they received in hospital following the birth.

The National Cancer Patient Experience Survey 2012/ 2013 was designed to monitor national process on cancer care. The trust was performing within the top 20% of trusts for 16 of the 34 areas, the middle 60% of trusts for 13 areas and in the bottom 20% of trusts for five areas. The areas where it was performing well better were:

- Patients not been given conflicting information
- Privacy when discussing condition/treatment
- Being able to discuss fear
- Treated with respect and dignity
- Given clear information
- Feeling they were given enough care
- Health got better or remained about the same while waiting for treatment
- Seen as soon as necessary
- Given a choice about the types of treatment
- Given the name of the nurse in charge of their care, given information of who to contact post discharge
- GP was given enough information
- Had confidence in the doctors treating them
- Did not feel doctors talked in front of them as if they were not there
- Had confidence in ward nurses
- Saw GP once or twice before being told they had to go to hospital.

The areas they scored in the bottom 20% were:

- Hospital staff told patient they could get free prescriptions
- All staff asked patient what name they preferred to be called
- Staff definitely did everything to control side effects of chemotherapy
- Hospital staff gave information about support groups
- Staff gave complete explanation of what would be done.

The patient-led assessment of the care environment (PLACE) programme are self-assessments undertaken by teams of NHS and private/independent healthcare providers and include at least 50% members of the public. They focus on the environment in which care is provided, as well as supporting non-clinical services, such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. The outcomes of the patient led assessments of the care environment for 2014 showed that the trust was rated worse than the England average for all areas.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Children and young people using the short break service were not protected against the risks associated with the unsafe use and management of medicines.
- Children and young people using the short break service, must be protected against identifiable risks of acquiring a healthcare associated infection.
- The provider must ensure that there are sufficient suitably qualified, skilled and experienced staff in the school nursing service to meet the needs of the local population.
- The provider must ensure that there is effective liaison between the contraception and sexual health service and the school nursing service about individual young people who may be at risk of abuse.

Action the provider SHOULD take to improve

- The provider should ensure that systems for reporting and recording safety concerns, incidents and near misses are used effectively and consistently.
- The provider should ensure that safeguarding supervision is robust and effective for all staff that need this.
- The provider should ensure that the substance misuse pathway is effective in providing appropriate intervention for young people under 16.

Summary of findings

- The provider should ensure that handovers from midwives to health visitors are taking place in a timely and effective way.
- The provider should ensure that the early attachment service is not over reliant on one practitioner.
- The provider should ensure that discharge criteria for the early attachment service are fully defined.
- The provider should ensure that staff are not hindered by old and inefficient IT equipment.
- The provider should ensure that all staff working with children, young people and families have received training about the identification and prevention of child sexual exploitation.
- The provider should ensure that young people have access to contraceptive and sexual health clinics during school holidays.
- The provider should ensure that waiting time targets are met for physiotherapy non-urgent appointments and child development centre appointments.
- The provider should ensure that letters to parents and carers include how to get the information in languages other than English.
- The provider should ensure that information about complaints is captured and shared, including when they are dealt with locally and not recorded on the reporting system.
- The provider should ensure that risks and concerns within the service are dealt with in an appropriate and timely way.
- The provider should ensure a consistent approach to obtaining the views of children, young people and families using the service.
- The provider should strengthen the engagement with staff delivering community health services for children and young people and improve communication about service design and strategy.

The Rotherham NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

The five questions we ask about core services and what we found

Inadequate

Are community children and young peoples services safe?

By safe, we mean that people are protected from abuse

We rated this service as inadequate because children, young people and families were at increased risk of avoidable harm.

Systems and processes were not always reliable or sufficiently robust to keep children and young people safe. The systems in place for reporting and recording safety concerns, incidents and near misses were not used effectively or consistently. Staff did not always have feedback about the action taken when they reported issues.

There were gaps and inconsistencies in safeguarding systems and processes. Complete and robust information was not always available for multi-agency decisions about children at risk of abuse.

There were no appropriate arrangements in place for the safe management of medicines in the short break service. Prevention and control of infection was generally well managed. However, there were practices that put children using the short break service at increased risk of acquiring an infection.

Despite having only a small amount of vacancies, the school nursing service was under pressure. The teams reported low morale and concerns about their caseloads. Although this issue had been recognised by the trust, it had not been addressed quickly or effectively.

Detailed findings

Incident reporting, learning and improvement

- The trust had an electronic system for reporting incidents. Staff told us that anyone could report incidents and they all knew how to use the system. However, there was limited and inconsistent use of it.
- There were 37 incidents reported between August and December 2014 that related to community health services for children, young people and families.
- For the reports seen, the categories for describing incidents were not used consistently or correctly. For example, an incident of alleged abuse was not reported as such because it was under the category of 'other'. An incident of unsafe management of medicines was also reported as 'other', rather than 'other medication incident'. This meant that incidents may not be correctly identified or responded to appropriately to ensure children and young people were protected. Members of the corporate patient safety team reviewed the incidents twice a week and did reclassify some that were obviously wrongly classified. In addition the executive team receive a daily report on all incidents submitted the previous day which can lead to some incidents being reprioritised.
- Most staff we spoke with said they felt cautious about reporting incidents and raising concerns. They felt that concerns were sometimes not dealt with appropriately by senior managers, (above team leader level).
- When we asked staff to give examples of incidents they would report, we found that some staff would not report incidents where it was perceived there was no harm to people using the service or staff. This meant that 'near miss' incidents were not always reported and so lessons could not be learned to reduce the risk of actual harm.
- Front line managers told us they found it difficult to be heard when raising concerns. They said they escalated concerns through their management and the safeguarding team but then issues were not progressed.
- There was a lack of consistency in staff receiving feedback from incidents they had reported. A health visitor said they had initially had received helpful feedback and support following an incident. However, when the same issue happened again, the health visitor felt the response from managers was not as supportive.
- Most staff we spoke with told us they had little or no feedback from incidents they had reported and so did not know what action had been taken or if there were any lessons to be learned.

Duty of Candour

- Managers were aware of the duty of candour regulation introduced in November 2014, (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The intention of this regulation is to ensure that providers are open and transparent with people who use services. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Safeguarding

- Most staff were familiar with the threshold descriptors for safeguarding and child protection concerns and understood the procedures to follow. This included health visitors, school nurses, nursery nurses and therapists. All safeguarding referrals we looked at were appropriate.
- We saw some examples of good quality multi-agency referrals where the risks to the child and / or others were set out clearly and succinctly. The expectations of the practitioner in making the referral were also identified. However, there were other examples where the risk of harm to the child and the purpose of the referral were not made clear. This meant it could be difficult for social workers to understand the significance of the referral, possibly leading to confusion and delay in putting plans in place to protect the child.
- Where health visitors and school nurses had made safeguarding referrals and were not happy with the response from social services, they escalated their concerns through their managers or the trust safeguarding team. However, there were some staff who were reluctant to challenge colleagues in other disciplines and there was an over-reliance on escalation to senior managers. This meant there could be delays in protecting children from abuse or neglect. The Local Safeguarding Children Board had recognised this problem and had a protocol in place to encourage and support professionals to resolve concerns early.
- Health visitors were proactive in working with families where child protection plans were in place. Health visitors acted as advocates for the child, challenging parents and other professionals appropriately to ensure the best outcomes for the child.
- Health practitioners were routinely attending child protection meetings and preparing reports where

needed. They were sharing reports with families, in line with best practice guidance. This included school nurses who were regularly asked to attend child protection meetings. However, the nurses were frequently given short notice of meetings by the local authority and were sometimes expected to attend more than one meeting on the same day. The school nurses were concerned that they were not always able to attend meetings due to insufficient notice and also because of reduced capacity in the school nursing service.

- The trust's safeguarding lead for children was on long term leave. The trust responded well to the opportunities that this has created to look at how front line practitioners could be better supported to be more confident and competent in working with vulnerable families. Other staff with relevant experience were providing cover for some aspects of the safeguarding lead role. However, safeguarding supervision was no longer being provided by the safeguarding team.Safeguarding supervision is an essential requirement for the professional development and support of health visitors and school nurses. Supervision is a dedicated time for the discussion of individual cases of concern about safeguarding children. This supervision had previously been provided by the safeguarding team. A review of supervision was underway.
- Safeguarding supervision was now provided as part of case management supervision for health visitors and school nurses. Some staff felt that this did not provide sufficient opportunity for reflection and support. This is important when working with complex families to ensure that practitioners remain emotionally strong.
- Risk assessments to identify vulnerability, including potential exploitation, were completed for young people attending contraception and sexual health (CASH) and genito-urinary medicine (GUM) services. The risk assessments for young people using GUM services were more robust than those seen for young people using CASH. Some of the (CASH) assessments were incomplete and so may not have been as effective in identifying young people at risk.
- The operational role of sexual health services in contributing to child sexual exploitation work was not well understood or well developed. There were no systems in place to ensure that intelligence about risk was appropriately captured and used.
- The potential role of CASH and GUM services in child sexual exploitation and child protection enquiries was not well understood. Staff working in CASH and GUM could not recall being asked to contribute to child protection enquiries. This meant that multi-agency risk assessments may have been incomplete.

Medicines management

- Medicines were safely managed by health visitors, school nurses, and other community nurses. They followed the trust's policies regarding the safe management of medicines. However, there were no appropriate arrangements for the safe management of medicines in the short break service.
- The short break service provided up to six hours of daytime care for children with complex care needs, allowing parents or carers a short respite. The trust's policy did not include specific guidance about how medicines for children using this service should be safely managed. The manager with responsibility for the service confirmed that there was no separate policy or written guidance available for staff working in the short break service.
- If a child needed prescribed medication, this was brought with them from home by the parent or carer for staff to administer. The medication was usually in a syringe, pre-filled and labelled by the parent with the child's name, the name of the medicine, and the time to be given. This was an unsafe system as staff could not be certain about the contents of the syringe. Staff would not know if it was the correct medicine or dose as prescribed, or if the medicine was within the 'use by' date.
- Medicines brought to the short break service were not stored securely. The medicines were stored in a locked cabinet, but this was not securely fixed to the wall. The key for the cabinet was kept on a hook next to the cabinet where it could be accessed by anyone entering the room. If medicines required refrigeration, they were stored in the kitchen fridge which any member of staff in the building would have access to. The medicines were stored in labelled bags in the fridge, but not in a locked container.
- When staff administered medication to children attending the short break service this was noted on the child's electronic record and also in a book used to record daily attendances of children using the service.

However, neither of these records showed the full details of the medicine, such as the strength, dose, times to be given, or any other instructions from the prescriber.
- Staff responsible for administering the medicines had not received training specifically about the safe handling of medicines. They were not aware of the expected or unwanted effects of the medicines they were administering.
- Many practitioners we spoke with were nurse prescribers. This meant they had undergone additional training to be able to prescribe a limited range of medication appropriate to their specific roles. They demonstrated good understanding of their role and responsibilities regarding prescribing.
- Nurses used Patient Group Directions (PGD) appropriately. PGD are specific written instructions for the supply and/or administration of a named medicine to specific groups of patients who may not be identified before presenting for treatment. PGD should only be used by a registered nurse or midwife who has been assessed as competent to do this. An example was the supply of contraceptive medicines for young people attending the contraceptive and sexual health service.

Safety of equipment

- Equipment was maintained in line with manufacturer's guidance and legislation, for example, lifting hoists were serviced every six months.
- Staff had received training in the safe use of equipment where this was necessary, such as lifting hoists.

Records and management

- Records were up to date and reflected the needs of each individual child or young person. Staff updated individual records following each consultation or intervention.
- Recorded entries followed good practice guidelines on record keeping from professional bodies, such as the General Medical Council and the Nursing and Midwifery Council.
- The electronic records were accessible to all those involved in the care and treatment of the child or young person. This meant that staff could see the input and treatment provided by all of the multi-disciplinary team.

Cleanliness, infection control and hygiene

- Staff were 'bare below the elbow' and we observed appropriate hand washing and use of hand sanitizer. Staff had access to personal protective equipment which included disposable aprons and gloves. When visiting children at home staff carried suitable supplies which included hand sanitizer and anti-bacterial wipes.
- Checks of hand hygiene of staff working in children and young people's services were carried out as quarterly audits. This audit also included staff compliance with being 'bare below the elbow'.
- Twelve teams were listed in the quarterly audits. For the last audit in December 2014, eight of these teams had not submitted any results for hand hygiene and nine had not submitted any results for compliance with being 'bare below the elbows'. Staff were aware of the audits taking place but had not received feedback about the results.
- The systems, processes and practices in place in the short break service did not adequately protect children using the service against the risks of infection. Children using the service were at increased risk of developing infections because of their complex health needs. There was no written guidance for staff about how to ensure effective cleaning of items and equipment used within the short break service. Staff practices were not in line with national guidance for the prevention and control of infection. For example, cloth play mats that had been used were either washed in a shower room within the building or taken home by staff to launder as there was no washing machine or other laundry facility provided.

Mandatory training

- The trust target was for 95% of staff to have completed mandatory training. It was difficult to ascertain from the evidence the trust provided how many staff had received mandatory training.
- Staff we spoke with said they were up to date with their mandatory training. They could use an online system to check what training they had completed and what was due.

Assessing and responding to patient risk

- Staff recognised and responded appropriately to deterioration in a child's health.
- Staff in the short break service were able to explain the procedures in place and gave examples of the action they would take if a child appeared unwell.

- There were appropriate risk assessments in place where staff were providing care and support to children with complex healthcare needs. For example, assessments of the risks associated with moving and handling for children who were not able to move around independently.

Staffing levels and caseload

- The trust was making progress toward meeting the number of health visitors required under the National Health Visitor Plan 2011-15 in line with the government's Health Visitor Programme. The purpose of the Health Visitor Programme, started in 2011, is to secure an extra 4,200 health visitors and transform the health visiting service across England by April 2015. The trust had a target of recruiting to 60 whole time equivalent health visitor posts. They told us they were on course to meet this target by the end of March 2015.
- Health visitors told us the recruitment of more health visitors had made a positive impact on the service and the outcomes for people using it. They said they were now able to work in a more proactive way, for example, making more use of early intervention and having more time to reflect on their practice.
- In August 2014, the trust identified a significant level of vacancies (28%) at band six and seven in the school nursing service. (The bands referred to are those used in the NHS to determine staff salaries, nine bands in all with nine being the most senior). The trust told us they tried but could not recruit to these posts and so converted them to band five posts. They had recruited six band five nurses although, at the time of our inspection, three of these were in post.
- The trust planned to support the band five nurses to undertake the school nursing qualification and then convert to band six on completion of this training. They estimated that it would take two years for this to be achieved. They planned to advertise band six roles again, but as specialist leads, such as for safeguarding or continence, to try to attract staff with experience.
- As band six was required for specialist school nurses, the band five nurses in post were unable to have a caseload that included children with a child protection plan in place.
- The school nursing team reported low morale and concerns regarding their caseloads. They had a small number of vacancies and the trust was recruiting to these. All of the school nurses we spoke with described their caseloads as unmanageable.
- Staff in the school nursing service told us the issues with high caseloads had been escalated through their managers and had been on the risk register for children and young people's services. However, this was removed from the risk register once the new staff had been recruited. Staff felt that there were still significant risks which should have remained on the risk register.
- School nurse caseloads included high numbers of children in need and children with a child protection plan in place. This meant that about 80% of their time was spent in fulfilling the requirements for supporting these children and their families. This included writing reports for safeguarding meetings as well as attending the meetings.
- School nurses were regularly asked to attend safeguarding meetings at short notice, sometimes more than one meeting in a day. This meant that other work seen as lower priority would be cancelled or moved. An example given was drop-in clinics in secondary schools being cancelled due to the pressure of safeguarding work. This limited the opportunities for young people to raise any health concerns.
- The school nursing service aimed to have a dedicated named nurse for each secondary school in Rotherham. Two out of sixteen schools did not have a named nurse, although other school nurses provided cover.
- School nurses said that the universal service they should provide to all children was affected by the lack of capacity within the service. This was reflected in data from the trust which showed that the number of children who had received a health needs assessment on entry to school had reduced during 2014 from 91.9% in April to 79.3% in December. The trust's target of 98% of children having this assessment had not been achieved. This meant that there could be delays in identifying and meeting children's health needs.

Managing anticipated risks

- The trust had a lone working policy in place. Staff we spoke with described lone working arrangements in line with the policy. Staff told us that lone working arrangements worked effectively to keep them safe.

- There were plans in place to ensure service continuity for situations such as bad weather or a flu pandemic affecting staff.
- There was a major incident policy in place with clear guidance for staff about the action to take depending on the type and urgency of the situation. There had not been any exercises to test the plan in the last 12 months

Requires improvement

Are community children and young peoples services effective?

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

We rated this service as requiring improvement because children and families were at risk of not receiving effective care or treatment.

Some key outcomes for children, young people and families using the service were regularly below expectations. Outcomes of care and treatment were not always consistently or robustly monitored.

Staff had the right qualifications, skills, knowledge and experience to do their job. However, staff were not always supported to attend training to help them develop additional skills and expertise. Staff working away from their office bases were hindered by old and ineffective IT equipment.

The care and treatment of children and young people was mostly planned and delivered in line with current evidence based guidance, standards and best practice. Consent to care and treatment was generally obtained in line with relevant guidance and legislation. However, staff were not always aware of the need to obtain consent for sharing information.

There were examples of collaborative and effective multi-disciplinary and multi-agency working to understand and meet the range and complexity of the needs of children and young people using the service. However, this was not consistent in all areas of the service as there were some gaps and missed opportunities.

Evidence based care and treatment

- Care and treatment for children and young people was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- The assessment of children with autism was in line with the relevant National Institute for Health and Care Excellence (NICE) guidance. Staff told us they were not always able to follow the NICE guidance for treatment of children with autism due to current demands on the service.
- The trust's policies were produced in line with national guidance. For example, the breast feeding policy referred to guidance from the NICE, the Department of Health, and the UNICEF UK Baby Friendly initiative.
- The trust provided the Healthy Child Programme. This is an early intervention and prevention public health programme. It offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices.
- The programme identifies the most appropriate opportunities for screening tests and developmental reviews, for assessing growth, for discussing social and emotional development with parents and children, and for linking children to early years services. The guidance is for these reviews to take place at around 14 days old, at six to eight weeks, by the time the child is one year old, and between two and two-and-a-half years old. The trust's programme included all of these reviews.
- The Family Nurse Partnership (FNP) was provided in line with national guidance for this programme. This included the 'Core Model Elements' of the programme based on research, expert opinion, field lessons and / or theoretical rationales.
- There was a substance misuse pathway in place for young people under 16. However, because of the capacity issues within the school nursing service, there was a risk that young people were not benefitting from intervention when they needed it. There had been no audit by the trust to confirm compliance with the pathway.

Nutrition and hydration

- Health visitors provided advice and support with breast feeding, weaning to solid food, and child nutrition. An assessment of the mother and baby's progress with breast feeding was part of the visit by the health visitor when the baby was 10 to 14 days old.
- The percentage of Rotherham mothers breastfeeding babies at six to eight weeks was lower than the England average according to data from Public Health England for March 2014. This had shown some improvement according to information provided by the trust up to

Requires improvement

Are community children and young peoples services effective?

December 2014, although this was still below the England average. The trust had recognised this issue and had taken action, such as recruiting a permanent coordinator who was responsible for breast feeding support and liaising with voluntary groups.

Use of technology

- Community staff were provided with laptop computers so they could access and update records when they were away from their office bases.
- There was no desktop computer in the short break service. A laptop computer had been provided but staff told us this was not always available. They used a desktop computer in a separate office when they needed to check or update records. They were only able to do this when there were no children using the service and so sometimes had to wait until the end of the day.
- Most staff reported connectivity issues when using laptops in some areas. This meant they sometimes could not access all the information they needed and had to return to their office or home to update records. Many of the laptops used by community staff were more than six years old, did not have sufficient memory and were not always compatible with newer software and technology. This was identified on the risk register for the children and young people's service. The risk register noted that it would be necessary to purchase new equipment, but there was no indication of when this would happen. The review date on the risk register was the end of December 2014 and there was no indication of a review or update. Managers we spoke with told us there were plans and money available to purchase IT equipment and a limited pilot of new equipment had started.

Outcomes of care and treatment and approach to monitoring quality and people's outcomes

- The trust monitored performance in specific areas, including the delivery of the Healthy Child Programme. Outcomes were regularly below expectations as the targets set were not always achieved.
- Every new baby discharged home from hospital should be visited by a health visitor between 10 – 14 days after birth. Data from the trust showed they had not met their target of 95% of these visits being carried out each month. From October 2013 to September 2014 91 – 93% of these visits were carried out.
- The targets for children receiving reviews at age two to two and a half were not met. 86 – 87% of reviews were carried out against a target of 90% from October 2013 to June 2014. 84% of reviews were carried out against an increased target of 93% from July to September 2014.
- The target for reviews of children at 12 months old was met from October 2013 to April 2014, but not for the following three months.
- The trust's target of 98% of children having a health needs assessment on entry to school was not met between April and December 2014. The number of children having an assessment had reduced during this period from 91.9% to 79.3%. This meant that there could be delays in the identification of health needs of children. The trust felt this reduction was due, in part by the administration of the seasonal flu vaccination campaign.
- There was a protocol in place to ensure safe and timely handover from the midwife to the health visitor. However, no audit had been undertaken to assure managers or commissioners of services that these handovers were taking place effectively.
- Letters were routinely sent to the parents and carers of four year olds to ask if they required any further help or support from health visitors. Responses were seen by health visitors who told us that response rates were variable. There was no overall monitoring or analysis of responses to identify actions that could be taken to improve this.
- There was an annual review and report on the Family Nurse Partnership produced in December 2014, showing the progress made by the service and the plans for the next 12 months. There had been good progress on reducing the number of teenage pregnancies in Rotherham, although this remained above the England average. Some of the action plans in the report lacked detail of the measures to be taken and did not always show how or when action would be completed.

Competent staff

- Newly employed school nurses told us they felt well supported in their teams and had received an appropriate induction.
- Staff told us their personal development and additional training needs were discussed at their annual appraisals. Some staff, such as those working in the audiology service, said they had been provided with the additional training they had asked for.

Requires improvement

Are community children and young peoples services effective?

- The senior leaders told us there was a training budget for staff to access additional training. Despite this, some staff didn't think there was one available, particularly when the training was to be sourced from an outside training provider. Examples given included a health visitor who had requested training on attachment theory and best practice, and school nurses who had requested training on eating disorders.
- The trust had identified a risk of therapists not being able to provide evidence of their required continuing professional development each year. This was because of a lack of formal training courses available and a reduction in the trust's training budget. There were some measures in place to manage the risk. Therapists told us they were concerned about the impact of the planned changes to the service on their training and development.
- The named nurses for looked after children regularly delivered training to health visitors and school nurses about the health needs of looked after children.
- Front line staff, including health visitors and school nurses, had received recent training about the identification and prevention of child sexual exploitation. This was multi-agency training and was well received by staff. However, not all staff had been able to attend but there were further sessions available.
- Not all staff working with potential victims of female genital mutilation had received relevant training. This meant that staff may lack awareness of how to identify and protect girls at risk and how to provide care and support for those who had already undergone female genital mutilation.
- There were plans to roll out training in perinatal mental health for health visitors. The training was planned to facilitate the implementation of an enhanced model of support for new mothers with mild to moderate perinatal mental health concerns.

Multi-disciplinary working and coordination of care pathways

- The use of Kimberworth Place assisted good partnership working between health and social services.
- The working and co-ordination of care pathways between midwives and health visitors was not always used effectively. Midwives were not making best use of the electronic system to alert health visitors to any significant issues during the woman's pregnancy, particularly around mental health. There was little opportunity for joint visits by midwives and health visitors to provide a co-ordinated approach for vulnerable and complex families.
- Young women who were looked after who became pregnant had effective multi-disciplinary support. There was close working between the looked after children's team, Family Nurse Partnership, teenage pregnancy midwife and a voluntary support service.
- Staff working in the contraception and sexual health (CASH) service described close working with the genito-urinary medicine service and close links with the police and social services. However, there was a lack of liaison between CASH and the school nursing service about individual young people.
- Staff in the audiology service described good multi-disciplinary working through the Children's Hearing Services Working Group. This group met monthly to discuss issues and any barriers to children needing hearing services. The group included parent representatives, staff from the children's hearing aid service, the new-born hearing screening manager, a senior paediatric audiologist, the educational audiologist from the local authority, and a family support worker. The group were looking at having an area group to improve connections with services in surrounding areas.
- There was joint working between health, social care and education staff to ensure funding for high cost specialist equipment for children.

Referral, transfer, discharge and transition

- Arrangements to transfer children from the health visiting to the school nursing service were well established. However, the capacity within the school nursing service meant the availability of support from school nurses was limited.
- There were established and effective arrangements in place to provide support to families with children under five who moved into the Rotherham area.
- The risk of young people with complex, on-going health needs not being transferred to the adult services they required at the age of 18 was identified on the risk register for the children and young people's service. Action had been taken to address the issue. This included ensuring young people were only discharged from the service when the transition to adult services

was complete. Staff told us that young people usually experienced a reasonably smooth transition to adult services, although the adult services did not always meet their expectations.
- The audiology service provided a clinic for young people aged 16 to 18 years. This provided young people with information and explanations of how their transition to adult services would be managed.
- Discharge criteria for the early attachment service had not been fully defined. This meant there may be people who could be discharged, enabling others who were waiting for the service to access it.

Availability of information

- The electronic record system was used by all staff which meant that individual practitioners could see the input from other colleagues. Staff could access the electronic records in office bases or remotely using laptop computers.
- Connectivity issues meant that staff sometimes could not access all the information they needed when working away from their office base.
- Paper records were kept in the short break service which meant staff had immediate access to essential information about the children, such as parent contact details, current medication, and information about allergies.
- The trust had identified a risk that information about the medical history of children and young people adopted into families of no blood relation could be lost or become inaccessible to healthcare staff. This was because these children and young people were given a new NHS number when they were adopted and a new record was created for them. This could be easily managed with the previous system of paper records, but the current electronic record system could not accommodate the change of NHS numbers. The trust had put some measures in place to manage the risk, although it had acknowledged this was a national problem and resolution at a local level was proving to be difficult.

Consent

- Consent to care and treatment was obtained in line with legislation and guidance, including the Children's Acts 1989 and 2004. Staff demonstrated an understanding of when and how to obtain consent and this was appropriately recorded.
- Consent by parents or carers to the sharing information was noted on each child's electronic records. Some staff were not fully aware of the need to ask for this consent.

Good

Are community services for children and young people caring?

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

We rated this service as good because children, young people and families were treated with compassion, kindness, dignity and respect.

Feedback from those using the service was positive about how they were treated by staff and about how they were involved in making decisions with the support they needed.

Dignity, respect and compassionate care

- All staff treated parents, carers and children with respect, kindness and compassion.
- Parents and carers were positive about how they and their children were treated by staff throughout the service.
- A parent told us their child had been frightened and reluctant to engage with staff on a previous visit to the child development centre. During our inspection we observed a therapist carefully and skilfully gaining the confidence of this child. The parent was pleased with the child's response and the progress they had made.
- We spoke with the parents of two children who had more complex health needs. One set of parents was very happy with the service but the other parents felt less supported and raised concerns with us about their childs care and treatment. We refered these concerns to the Chief Nurse so they could be looked into further.
- We observed staff in the short break service engaging with children, providing reassurance and therapeutic intervention in a fun and friendly way.

Patient understanding and involvement

- Parents, carers, children and young people were involved in making decisions about their care and treatment.
- We observed staff in clinics and on home visits explaining support and treatment to children and parents and allowing opportunities for any questions.
- Speech and language therapists used diagrams as well as a verbal explanation to ensure parents understood their child's issues.
- Staff in the audiology service explained to parents that future appointments may be in a different place so to check carefully when they received their next appointment letter.
- Information leaflets were provided for parents and carers and also in formats suitable for children and young people.

Emotional support

- Most of the parents we spoke with said they had good continuity of care with their health visitors. One parent said they were reassured by having the same health visitor following the birth of their child.
- Parents and carers using the short break service were offered additional opportunities for respite care whenever possible. When staff knew a child would not be attending as planned, they offered the place to other children using the service.

Promotion of self-care

- Health visitors had introduced clinics where parents or carers could weigh their own babies for reassurance.
- Health visitors and the early attachment worker provided practical support and strategies for parents / carers with the aim of reducing professional input.
- Young people were supported to take responsibility for their sexual health through the contraception and sexual health service and the Family Nurse Partnership.

Requires improvement

Are community services for children and young people responsive to people's needs?

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

We rated this service as requiring improvement because the needs of children, young people and families were not always met because of the way some services were organised and delivered.

Waiting time targets were not met for physiotherapy non-urgent appointments and child development centre appointments. This meant that children and young people were experiencing delays in receiving treatment and support for their health needs. Children referred for speech and language therapy were seen within target times for their initial assessment, but then were waiting for treatment.

Many of the contraceptive and sexual health clinics provided were held in schools and colleges and so were not available during the school holidays. This limited the opportunities for young people to seek advice and treatment.

Other services were planned and delivered in a way that met the needs of the local population. Examples included the Family Nurse Partnership, the audiology service, and a health visitor service for children, young people and families who were asylum seekers.

Planning and delivering services which meet people's needs

- The Family Nurse Partnership was well established in Rotherham. The Family Nurse Partnership is a home visiting programme for first time young mothers, aged 19 or under. A specially trained family nurse visited young mothers regularly from early pregnancy until the child was two. Participation in the programme was voluntary for young mothers. The family nurses were working closely with other health and social care professionals, using joint visits to provide a co-ordinated approach.
- There was an early attachment service. Health visitors could refer families where there were concerns around bonding between mother and baby. The service was well regarded by people using it and by health visitors. However, the service was currently vulnerable as it was over reliant on one health visitor.
- There were specialist services available for children and young people with asthma, epilepsy, diabetes and attention deficit hyperactivity disorder.
- Contraceptive and sexual health (CASH) services were available to young people in Rotherham in the main clinic at a central health centre and at satellite clinics . However, many of the satellite clinics were held in schools and colleges and so were not available in school holidays. The service had started to analyse the take up by young people and had recognised that the location of clinics needed review.
- The audiology service provided a joint clinic with nurses and audiologists. Children were seen by a nurse first to check for ear infections or excessive ear wax, then went on to have audiology tests. The aim was for children to go away with a hearing aid and staff said this was achieved for around 50 to 60% of those seen. This was an improvement on the previous system where the whole process could take up to six months.
- The trust's wheelchair and equipment service was available to children and young people. Children and young people were able to 'test drive' a new wheelchair on a course set up for this purpose. At our public listening event, two separate sets of parents raised concerns with us about the wheelchair service and that they found it hard to get the right support and equipment for their child.
- The clinics we visited provided a suitable environment for children. The facilities and premises were appropriate for the services being delivered.

Equality and diversity

- Interpreters were used as required where parents did not have English as their first language. Staff knew how to access an interpreter, by telephone or face to face.
- We observed practitioners using interpreters and checking parents' understanding. Practitioners told us they would often ensure a longer appointment was booked when an interpreter was needed.
- Letters to parents and carers were often sent out in English with no indication of how to get the information

Requires improvement

Are community services for children and young people responsive to people's needs?

in other languages. An example of this was the letter sent to the parents / carers of four year olds asking if any further help or support from a health visitor was required.

Meeting the needs of people in vulnerable circumstances

- Vulnerable and hard to reach young people were well supported by the CASH outreach nurse, including home visits for those who could not attend a local clinic. The outreach nurse had an innovative approach to using social media to maintain contact with some of the young people.
- There were advanced plans to implement an enhanced model of support for new mothers with mild to moderate perinatal mental health concerns.
- There was a health visitor providing a service specifically for children, young people and families who were asylum seekers.

Access to the right care at the right time

- Children and young people referred for speech and language therapy were seen within eight weeks, meeting the trust's waiting time target. This indicated an improvement on data from 2014 that showed regular breaches of the eight week target and an average waiting time of 10 weeks.
- Speech and language therapists told us there was a focus on achieving the initial assessment targets, but this was creating longer waiting times for children requiring treatment. This meant that children needing minimum intervention could be assessed and given appropriate advice and support at the initial assessment appointment. However, children with more significant problems were left waiting for treatment. The therapists felt this had not been acknowledged as an issue by senior management who were preoccupied by the need to meet the targets for initial assessment only.
- Waiting time targets were not met for physiotherapy non-urgent appointments and child development centre appointments. The trust target for physiotherapy was four weeks but children were currently waiting 11 weeks. For the child development centre the trust target was six weeks and children were currently waiting 11 weeks.
- At our public listening event, parents raised concerns with us about access to physiotherapy, occupational therapy and speech and language therapy and told us they felt it was becoming more difficult to get the right support for this child due to pressures on the service.
- Staff working in the child development centre told us that action had been taken to reduce the waiting list for child assessments. However, this included a requirement to have five children booked into an assessment session, (previously there had been a maximum of four children per session). The children were assigned to the session by administration staff and so there was no recognition of individual clinical need. Staff said the size of the room used for assessment was not sufficient for five children, particularly as they were accompanied by parents or carers and sometimes siblings.
- Therapy staff said the waiting list delays for physiotherapy were due to long term sickness absence within the team.
- A doctor told us there had been an increase in identifying children who may have autism and, consequently, a higher number of referrals for assessment of these children. This had led to increased waiting times for assessment appointments. Appointments had been reduced in length from an hour to 45 minutes to reduce waiting times. Although this had a positive effect on waiting times, staff felt there was a risk that the quality of the assessment would be compromised, particularly for children with complex needs and / or challenging behaviour.
- There were no clearly defined pathways for the early attachment service including a lack of criteria for discharging mothers from the service. This meant there may be people using the service who could be supported through their usual health visitor, making room for others in greater need.
- Text messaging was used to remind parents of children attending the child development centre of their appointments.

Complaints handling (for this service) and learning from feedback

- Information was displayed about how to make a complaint. None of the parents or carers we spoke with had made a complaint.
- Staff told us they usually dealt with complaints locally, taking action to prevent the complaint escalating.

Requires improvement

Are community services for children and young people responsive to people's needs?

Although this usually meant a good outcome for the complainant, it also meant that information about these complaints was not captured as nothing was recorded on the reporting system. This may result in learning from complaints not being widely shared.

- Action was taken in response to complaints. For example, complaints about insufficient staff available to answer telephone calls in the audiology service had resulted in the employment of an additional member of staff.

Requires improvement

Are community children and young peoples 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.

We rated this service as requiring improvement because the leadership, governance and culture did not always support the delivery of high quality care for children, young people and families.

Risks and concerns were not always dealt with appropriately or in a timely way. The risks and issues described by staff did not always correspond to those reported to and understood by their leaders.

Leaders in the service were not always clear about their roles and their accountability for quality. The need to develop leaders was not always identified or appropriate action taken to support leaders.

Staff did not feel actively engaged or empowered. When staff raised concerns or ideas for improvement, they felt they were not always taken seriously.

There was an inconsistent approach to obtaining the views of children, young people and families using the service.

Service vision and strategy

- The trust's vision and values were displayed in their premises and also on their website. Most staff we spoke with knew about the core values.
- The community services were reorganised following their transfer to the trust in 2011. Further changes and reorganisation were in process and planned for the children and young people's service.

Governance, risk management and quality measurement

- Community health services for children, young people and families were managed in the trust's Family Health division together with acute services.
- Lines of responsibility and accountability were not clear to staff. Staff we spoke with were not always sure about the management structure above their team leaders. They could not describe clearly the roles of the managers above the team leaders.
- Quality and risk information about community health services for children, young people and families was reviewed at divisional and board level. However, there was very little information published by the trust regarding safeguarding children and looked after children.
- The risk register for the children and young people's service included 11 risks for community health service. There were details of measures in place to manage the risks and most risk rating levels had reduced over time. Review dates for risks were overdue for two risks and there appeared to be a long time between reviews for other risks. For example, a risk related to waiting times for therapy services appeared to have been last reviewed in August 2013 with the next review date of 31 March 2015 despite no reduction in the risk rating.
- The risk register did not include any risks related to the school nursing service, despite the ongoing concerns raised by staff regarding staffing levels and workloads.

Leadership of this service

- Most staff we spoke with were positive about the trust's chief executive. However, they felt that senior managers were not visible or supportive.
- Staff lacked confidence in the managers above team leader level. Staff didn't feel listened to and didn't feel their leaders understood the service in any detail.
- School nurses had met with the chief nurse, matron and safeguarding lead in October 2014 to discuss their concerns. School nurses told us they had also asked to meet with the trust's lead for children's services to discuss, but this had not happened. They said they did not feel sufficiently heard by managers when they raised concerns.
- A therapist manager post had been made redundant and the lead nurse for children had taken on the role and overall responsibility for the therapist team. Therapists felt that, in practice, this meant they had no strategic lead. They felt they were expected to pick up and carry out management responsibilities with no training and little support.

Requires improvement

Are community children and young peoples services well-led?

- Some team leaders were not able to make or take part in budget decisions affecting their team, despite the usual expectation of staff at their level to do this. They found this frustrating and felt their leadership skills were undervalued.

Culture within this service

- Most of the staff we spoke with described good support and effective working relationships with their team colleagues and their immediate line managers.
- Most staff were less positive about senior managers within the service because they didn't feel they listened to them and they didn't receive feedback when they raised areas of concern. Staff had raised concerns and ideas for improvement but felt they were not always taken seriously by management.
- Staff described reactive responses from senior managers, often looking to blame rather than act pro-actively to address concerns.
- Staff were proud of their work and the outcomes for the children and families they supported. Most staff told us they felt staff morale was low as staff were feeling stressed by the changes happening within the trust.

Public and staff engagement

- The NHS Friends and Family Test was not being used for community health services for children, young people and families. There was no other consistent method in use to seek the views and feedback of families using the service. This meant that some parts of the service were actively seeking feedback and acting on the results, but other areas were not doing this.
- The audiology service was using surveys to collect the views of people using the service. This included a survey carried out every 14 to 16 months of satisfaction with the new-born screening service. Results of the surveys were positive. The audiology service had also used surveys to consult parents on a proposal to provide all of the service at one centre, rather than some services being carried out at the hospital. This was a popular proposal with parents and was implemented.
- The child development centre had moved from the hospital site to Kimberworth Place. An audit of parent / carer's views regarding the move had been carried out. Although the results had not been fully analysed, there were positive responses regarding multi-agency access and better car parking. Negative responses were received about access using public transport and the need for children to attend the hospital if blood tests were required.
- The wheelchair and equipment service used a monthly telephone survey of people using the service, including parents of children using equipment provided. Overall satisfaction with the service was regularly rated at 90% or higher, (for all users of the service – it was not possible to break down the results to show the response from children / their parents or carers).
- The results of the NHS staff survey for 2013 showed that the overall score for staff engagement was in the lowest (worst) 20% when compared with trusts of a similar type. This had not changed since the survey in 2012.
- The trust had taken action to engage with staff, including 'Listening in Action' events run by the chief executive. Most staff we spoke with were aware of these events, though few had attended.
- Many of the staff we spoke with felt that community services came second to the acute services. They felt that the value of their work was not always recognised by the trust board and senior managers.
- Therapists told us they had not been properly consulted about or involved in proposed changes to their service. They told us they had raised concerns about being given very short notice of consultation and they understood this was now 'on hold'.
- School nurses told us they did not feel engaged with management to participate in finding solutions to the current issues within the service.

Innovation, improvement and sustainability

- Staff we spoke with felt that reorganisation was driven by financial requirements, rather than to improve the quality of services. An example given was that the role and responsibilities of a manager had been increased when other managers were made redundant. This had resulted in one manager having responsibility for a wide and diverse range of services. Staff felt this meant a dilution in the availability and quality of management at this level for each service.
- Therapists were concerned that the planned changes for their service would result in a loss of expertise and would affect the safety and quality of the services they delivered. A therapist told us, "The new structure is setting us up to fail. There's a big risk to families and many staff are considering a redundancy application."

Requires improvement

Are community children and young peoples services well-led?

- Funding had been made available to increase the Family Nurse Partnership programme. This currently had capacity for 125 young women / families and had expanded by 25 places in 2014. Further expansion was planned once the programme was considered ready for this.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Children and young people using the short break service were not protected against identifiable risks of acquiring a health care associated infection.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Children and young people using the short break service were not protected against the risks associated with the unsafe use and management of medicines.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider must ensure that there are sufficient suitably qualified, skilled and experienced staff in the school nursing service to meet the needs of the local population.**

Regulated activity	Regulation
Family planning services Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider must ensure that there is effective liaison between the contraception and sexual health service and the school nursing service about individual young people who may be at risk of abuse.**

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.