Bristol Community Health C.I.C.

1-296908348

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)
1-304870639	Bristol Community Health Headquarters	School Nursing Team, Osprey Court	BS14 0BB
1-304870639	Bristol Community Health Headquarters	Physiotherapy and Occupational Therapy Team, Ilminster Avenue Specialist Children's Centre	BS4 1HR
1-304870639	Bristol Community Health Headquarters	Health Visiting Team, Hartcliffe Children's Centre	BS13 0JP
1-304870639	Bristol Community Health Headquarters	School Nursing Team, Filton Avenue Primary School	BS7 9RP
1-304870639	Bristol Community Health Headquarters	Health Visiting Team, Amelia Nutt Clinic	BS13 8QA
1-304870639	Bristol Community Health Headquarters	School Nurse drop in clinic, Brunel Academy Speedwell Road	BS15 1NU
1-304870639	Bristol Community Health Headquarters	School Nursing Team, Eastgate Hub	BS5 6XX
1-304870639	Bristol Community Health Headquarters	Health Visiting Team, Wellspring Healthy Living Centre	BS5 9QY
1-304870639	Bristol Community Health Headquarters	Physiotherapy and Occupational Therapy Team, Warmley Park School	BS30 8XL
1-304870639	Bristol Community Health Headquarters	Multi-disciplinary Team meeting, New Siblands Primary School	BS35 2EG
1-304870639	Bristol Community Health Headquarters	Barnardos Junction 3 Library	BS5 0FJ
1-304870639	Bristol Community Health Headquarters	Physiotherapy Team, Briarwood Special School Primary	BS16 4EA
1-304870639	Bristol Community Health Headquarters	Speech and Language Therapy Team, John Milton Clinic	BS10 7DP
1-304870639	Bristol Community Health Headquarters	School Nursing Team, Minerva Academy	BS16 4HA

Summary of findings

1-304870639	Bristol Community Health Headquarters	Immunisation Team, Oasis Academy	BS4 5EY

This report describes our judgement of the quality of care provided within this core service by Bristol Community Health Headquarters C.I.C. 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 Bristol Community Health Headquarters C. I.C. and these are brought together to inform our overall judgement of Bristol Community Health Headquarters C. I. C.

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall, we found community health services for children and young people required improvement because:

- There was an inconsistent understanding of what constituted an incident.
- Not all staff were compliant with safeguarding training.
- We saw examples where staff did not follow the required infection control protocols with regard to hand washing, cleaning of equipment and toy cleaning.
- Health visiting teams did not maintain an individual set of records for each child in one family and filed records under the youngest child's surname.
- Children transferred between the health visiting team and the school nursing team without a full set of records.
- There were inconsistencies in relation to how school nurses managed information about children who had attended the emergency department or urgent care centre.
- There were challenges to staffing due to sickness, vacancies and high turnover. The organisation also faced challenges filling vacancies with bank staff and there were issues around the accuracy of the data recorded about the numbers of back staff being requested and used.
- Some health visitor caseloads exceeded average caseload guidelines as recommended by the Royal College of Nursing.
- The service had not issued all appropriate members of staff with a mobile phone and there were inconsistencies between teams about how lone working and staff safety was managed.
- The information technology issues had challenged the service, due to the loss of data regarding mandatory training during the transition of services to Bristol Community Health from the previous providers in April 2016, which was still occurring and had not been resolved.
- The service was falling below key performance targets for new birth visits and child developmental reviews.
- Only the health visiting team had formal guidelines to support staff to manage the transition of children between services.
- Not all staff had completed an appraisal in the past 12 months.
- The principles of Gillick competence were not respected with regards to the immunisation of young people.
- Staff had experienced difficulty when arranging interpreting services.
- There were disjointed operational processes, with different systems and processes to follow between the different organisations in the Community Children's Health Partnership.
- There were limited processes, such as clinical audit, to monitor and improve quality.
- Not all risks associated with the services had been recorded on the risk register.
- Not all staff were clear with their new roles and lines of accountability since the transition of services from the previous provider to Bristol Community Health in April 2016.
- There were not enough team leaders in the school nursing team to effectively manage the workforce and keep up to date with supervision and appraisals.
- There was no systematic process of audit to monitor service quality and performance.
- Not all children's services had standard operating procedures or guidance for the transition of children into adult services.

However:

- There were systems and processes to safeguard children from abuse and staff were aware of these.
- Staff completed risk assessments as part of the assessment process for children receiving treatment from Bristol Community Health.
- There were systems and processes to follow if a child did not attend an appointment.
- Policies and care pathways were developed in line with national guidance.
- There was good multidisciplinary working between the various teams within Bristol Community Health and other external agencies.
- Staff treated children young people and their families with compassion, dignity and respect. They understood the importance of involvement of the family and those close to them.

Summary of findings

- Services were planned and delivered in a way, which met the needs of the local population. Children and their families were involved in service planning.
- There were actions to address referral to treatment times in the services, which were not meeting targets.
- There were clear strategies to improve services.
- Leaders of all levels were visible and approachable.
- The service worked closely with a local children's charity to ensure service user engagement to help improve services.

Summary of findings

Background to the service

Bristol Community Health took over the provision of children and young people's services in April 2016 as part of an interim, year-long contract commissioned by the local clinical commissioning group. Bristol Community Health provided services for children, young people and families as one of the providers for the Community Children's Health Partnership (CCHP). Bristol Community Health was part of a consortium of two other experienced children's service providers within the CCHP. Bristol Community Health delivered therapy services for children, young people and families in Bristol and South Gloucestershire.

The service worked with infants, children and young people aged 0 to 18 years of age, their parents, carers and a range of other agencies to provide care, support and treatment. A well-established children's charity worked closely with Bristol community Health and formed a distinctive element within CCHP, supporting service user engagement and participation to aid service planning and delivery.

Bristol Community Health delivered services at three localities across the north, south, east and central localities in Bristol and across South Gloucestershire, with staff covering different geographical areas. Services were delivered at clinics, within community settings, schools, children's centres or in children's homes. The services provided by Bristol Community Health were health visiting, school health nursing, speech and language therapy, physiotherapy, occupational therapy, immunisation services, safeguarding and school nurse drop in sessions for young people at local schools.

During our inspection, we visited clinics, therapy staff bases, schools, children's centres and children's homes. We visited physiotherapy, occupational therapy and speech and language clinics, and a sexual health drop in clinic. We accompanied health visitors and school nurses on community visits and in clinics. We met with the safeguarding lead for children, child protection supervisors, link workers and staff from the charity.

During our inspection, we spoke with 67 staff, 20 parents and 14 children. We observed how children and young people were cared for, held focus groups for staff and looked at 21 care and treatment records.

Our inspection team

Our inspection team was led by:

Chair: Robert Aitken, invited independent chair

Team Leader: Alison Giles, Care Quality Commission

The team included CQC inspectors and two specialist advisors: A children's nurse and a health visitor. We were also supported by two experts by experience who talked with patients who had consented to talk with us by telephone about their views and opinions.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

Summary of findings

How we carried out this inspection

During our inspection, we reviewed services provided by Bristol Community Health. We visited clinics, patient's homes and therapy bases across Bristol and South Gloucestershire.

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 15 to 18 November 2016. During the inspection, we held focus groups with a range of staff who worked within the service, such as nurses, therapists. We talked with 14 children and young people, 20 parents and carers who used the services. We observed how people were being cared for and reviewed 21 sets of treatment records. We carried out an unannounced visit on 30 November 2016.

Outstanding practice

- Staff respected and recognised each child as an individual. We observed outstanding caring from staff who were singing a song to each individual child and addressing them using their name when they entered the room for their therapy session. These children had profound needs, and we recognised how their faces lit up when they came into the session and had their special song.
- Families and carers of children and young people provided consistent positive feedback about the service. One parent told us "staff are so supportive and helpful," "staff are always there when you need them," while another told us "staff are really friendly, helpful and always welcoming." Another mother told us '"the service is brilliant, couldn't have asked for a better one."

Areas for improvement

Action the provider MUST take to improve

- Take action to ensure all staff receive the appropriate level of safeguarding training for their role.
- Ensure a complete set of records are transferred with the child from the health visiting team to the school nursing team in line with Royal College of Nursing guidelines.
- Take action to ensure the health visiting team maintains an individual set of records for each child, which are filed under the individual child's surname.
- Ensure staff comply with safe systems to ensure that toys are cleaned in line with the Cleaning and Decontamination of Toys' policy and ensure there is a system to monitor compliance around toy cleaning. We also observed poor compliance with hand washing and cleaning of equipment between use after each child.
- Ensure compliance with staff mandatory training and appraisal.
- Ensure there are standard operating procedures for the transition of all children into adult services.
- Take action to ensure there is a systematic process of audit to monitor service quality and performance, for example records audits, auditing the single point of access system.

Action the provider SHOULD take to improve

- Make sure all staff understand the definition of an incident and what should be reported.
- Ensure all staff are trained and familiar with the incident reporting policy and reporting system and are registered to use it.
- Establish consistent and complete record keeping in the child's personal child health record.

Requires improvement

Are services safe?

- Consider foot pedal operated bins are available to prevent the spread of infection.
- Make sure equipment is changed and replaced after each child to prevent the spread of infection.
- Ensure regular hand washing or application of hand gel after contact with each child.
- Establish regular cleaning of equipment after use with each child.
- Review the consistency between how school nursing teams manage information regarding a child's attendance at the accident and emergency department or urgent care centres.
- Make sure heath visitor caseloads are in line with the Royal College of Nursing guidelines.
- Establish a system for the speech and language team to monitor individual caseloads.
- Review the codes that capture work completed by staff, to ensure they represent the actual work taking place.
- Make sure the small number of school nurses required to provide contraception and sexual health advice are competent to carry out their role.
- Make sure the principles of Gillick competence are respected, with regards to immunisation of young people.
- Establish a system to ensure the safety of school nurses when they are lone working.
- Provide all appropriate staff with a mobile phone from the organisation, for safety and security when working alone.
- Make sure staff follow lone working policies and using the buddy system effectively to ensure their safety.
- Ensure school nurses adhere to set criteria for accepting or not accepting children into the service.
- Provide all services with information about the new working arrangements for the heath visitors to ensure safer transfer of records.
- Make sure information available is used effectively to avoid repetition and poor use of time at appointments with the school nurses.
- Inform parents when children do not consent for screening in line with national guidance.
- Ensure that the health visiting teams are meeting their performance targets with regards to newborn baby screening and developmental reviews.
- Ensure the provision of effective arrangements are in place to access and receive interpretation services for children, young people and their families.
- Make sure young children are not used to translate during treatment sessions for their siblings.
- Provide consent forms in different languages for children and their families whose first language is not English.
- Establish consistency between the operational processes and systems throughout the service within Bristol Community Health and the Community Children's Health Partnership.
- Make sure all senior staff have a clear understanding of their role and responsibilities and accountability within the service.
- Establish sufficient numbers of clinical lead staff to support the workforce effectively.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse and avoidable harm

Summary

Overall we rated the safety of the children and young people's service as requires improvement because:

- Not all staff demonstrated an understanding of what an incident was and what they should be reporting.
- There was a risk that incidents were being under reported because staff had not registered to use the incident reporting system and did not feel an incident was worth reporting unless something could be done about it.

Requires improvement

Are services safe?

- There was no system or process to ensure soft toys were cleaned to stop the spread of infection, there is poor compliance with hand washing and cleaning of equipment in-between use with each child.
- Health visitors did not maintain an individual set of records for each child in one family.
- Of the records inspected, we observed health visitors had transferred an incomplete set of the child's records to the school nursing team when the child transitioned between the teams.
- There was a lack of compliance with mandatory training. Training data had been lost during the transfer of the service to the new provider and were still experiencing challenges in relation to storing mandatory training data on the electronic system.
- There was a lack of consistency about how school nurses managed information they received about children who had attended accident and emergency departments.
- There were challenges to staffing due to sickness, vacancies and high turnover and covering staff absences with bank staff. Health visitor caseloads were inconsistent and higher than the average caseload guidelines set out by the Royal College of Nursing.

However:

- There were effective systems to safeguard children and young people from harm.
- Staff received support through supervision sessions with child protection supervisors if they were engaged in child protection and safeguarding cases.
- Records were reviewed when a police protection order was issued and learning was shared between the teams to improve practice and recording of cases in the future.
- The service completed risk assessments and actions to mitigate any risks to children as part of the assessment process for children receiving a service.
- There were systems and processes for staff to follow if a child did not attend an appointment.

Detailed findings

Safety performance

- There had been no serious incidents or never events involving children and young people within the last 12 months. A serious incident is an incident determined by the Department of Health as serious, largely preventable patient safety incident, which should not occur if the available preventative measures have been implemented correctly.
- There had been 31 incidents reported between July and September 2016 of which nine related to patient safety. Examples of incidents reported were the lack of suitably trained staff among health visitors and school nurses, incidents regarding injury and ill health, safeguarding children incidents, information governance issues and records management and health and safety issues.

Incident reporting, learning and improvement

- There was inconsistent understanding among staff across the children and young people's service about what constituted an incident and what should be reported. There was an electronic system to allow incidents to be reported and investigated appropriately. However, staff gave mixed reports as to whether they had received training for the electronic reporting system. All staff had access to the incident reporting system; however not all staff had accessed the incident reporting system to create their own log in or report an incident. The executive management team was aware that incident-reporting levels within the children and young people's service were low. We saw evidence that work was ongoing to raise the awareness of the importance of reporting incidents and to improve the incident reporting culture.
- Staff had access to an incident reporting policy via the intranet. The policy defined incidents that needed to be reported and contained a flow diagram and a description of the process to follow to report an incident. Staff were aware of the policy, but given the inconsistent picture of staff's understanding of incidents, we were not assured they had read and were familiar with the policy.
- Some staff provided us with examples of incidents they had reported. Some school nurses we spoke with demonstrated knowledge and understanding of how and when to report an incident. We were given examples of incidents they had reported and the actions, which had followed. For example, one school nurse had received support from the security staff after being subject to verbal abuse.

Requires improvement

Are services safe?

- Some staff we spoke with said the incident reporting process was time consuming to complete, which discouraged them from reporting an incident.
- Learning from incidents was cascaded to the wider teams. The therapy staff told us about an incident which occurred where a sibling of a child who attended a treatment session had an accident during the therapy session. From this incident, learning and actions were cascaded to therapy teams, which required parents to remain in the treatment room while the child was having their therapy session and parents had to take responsibility for their children. We saw posters in treatment rooms to remind parents of their responsibilities.
- The service produced highlight reports for the Community Children's Health Partnership governance meetings on a quarterly basis to identify themes and trends around complaints and incidents. Reports were discussed at quarterly clinical governance meetings. September's meeting identified a risk of under-reporting incidents as not all staff had registered on the incident reporting system. The minutes for the September 2016 governance meeting had identified actions to mitigate the risk, and allocated to a named person implement and reduce the risk of under-reporting.
- The operations manager discussed incidents at monthly one-to-one sessions with clinical team leaders. There had been no incidents reported by the physiotherapy or occupational therapy teams within south Bristol, but two incidents reported by the speech and language team.
- The speech and language team had reported two incidents, both of which related to information governance, where the confidentiality of patients' records was compromised. Action had been taken by the service to reduce the risk of the incidents reoccurring.
- Learning from incidents was shared among the school nursing service teams through discussion at the monthly professional forums.

Duty of Candour

- Staff demonstrated an understanding of the duty of candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. We saw evidence where the duty of candour had been employed within the service.
- The senior management team, clinical leads and staff we spoke with demonstrated an awareness of this regulation and could explain their responsibilities in relation to it. Staff spoke of their practice of being open and transparent with the families they worked with. Staff told us the duty of candour regulation was covered during the induction training they received following the transition of the service to Bristol Community Health in April 2016.

Safeguarding

- There were policies, systems and processes to keep children and young people safe and safeguarded from abuse. There was a clear safeguarding child protection policy available for all staff on the intranet. The policy covered definitions of safeguarding and the responsibilities of staff to report any suspicions of abuse for vulnerable children and young people. The policy contained information and flow charts about how to raise a safeguarding concern. This information was also visible around the various bases for staff to access quickly. Staff provided us with examples of when they had encountered safeguarding concerns and how they had handled them.
- Staff were not fully complaint with safeguarding training. In October 2016, 77% of staff had completed level one safeguarding training, whilst 81% had completed level three training. This was against the organisations target of 90%. There was 100% compliance with level four safeguarding children's training, which represented just one member of staff from the team. The safeguarding lead told us the lack of compliance was due to the challenge of obtaining accurate data from the previous service provider. Safeguarding training was in line with guidance from the Safeguarding Children and Young People Intercollegiate Document 2014. Staff also completed safeguarding adults training, with 82% having completed level one training but only 46% of staff were complaint with level two adult safeguarding training.

Requires improvement

Are services safe?

- There was a process to monitor children's attendance at accident and emergency departments. This was set up following learning from Victoria Climbie case in 2000. Health visiting teams received information from urgent care centres and local accident and emergency departments when children and young people had attended these services. The services faxed information regarding attendance to the child's main health visitor for review. The health visitors then followed a standard procedure of documenting the attendance in the child's records to ensure a complete chronology of events, along with any actions required.
- There were two serious case reviews in progress during the time of our inspection. A serious case review takes place after a child dies or is seriously injured and when abuse or neglect is thought to be involved. The review looked at lessons, which could help prevent similar incidents from happening in the future. A member of the management team told us the findings of the reviews, once completed, would be used as part of safeguarding training and disseminated to staff at team meetings.
- There was a system to identify children on a child protection plan. Health visitors and school nurses had access to an electronic system, which held a record of the child, demographic information, contacts with health visitors and whether they were on a child protection programme. Health visitors also kept details of the child protection plans in a file, locked away. This enabled a quick and clear process to access information to identify children on child protection plans if a new health visitor was to take over the caseload.
- Staff working for the children and young people's service had completed training on female genital mutilation (FGM) child sexual exploitation and modern slavery. These all formed part of the face-to-face long level three safeguarding training.
- There was a clear system supporting staff to report concerns about FGM to keep young people safeguarded from abuse. The Safeguarding Child Protection Policy, which covered FGM, provided a flow chart for staff to follow in order to report concerns. The Community Children's Health Partnership also ran a 'Star Clinic' where children or young people could be referred if there were any concerns of FGM or sexual abuse.
- The bilingual assistant practitioners provided support to the school nurses when required, about FGM. School nurses had asked the bilingual assistant practitioners to go and speak to families where there was potential risk of FGM, to explain about the legalities of FGM in the United Kingdom.
- The children's safeguarding lead was aware of the latest Care Quality Commission report Not Seen Not Heard. This was a review published in July 2016 to review the arrangements for child safeguarding and healthcare for looked after children in England. Four key recommendations came out of this report, which included; children must have a voice, there must be a focus on outcomes and more work to identify children at risk of harm and children must have access to the emotional and mental health support they need. The safeguarding lead for children told us there was a working party undertaking preparatory work in November 2016 on how to embed the learning points and actions from the report into practice.
- There were clear lines of reporting for safeguarding. There was an operations and strategic meeting, which fed into the Bristol Community Health Safeguarding Children meeting, led by the safeguarding children's lead. This fed into the quality harm free care group was chaired by the Deputy Clinical Director of Bristol Community Health. This then fed into the quality and assurance and governance committee, which then fed directly into the overarching Bristol Community Health Board.
- The clinical director attended the Bristol Safeguarding Children's Board. The board was made up of several organisations, working together to promote children's welfare and keep them safe. It included agencies such as the police, probation service and Bristol City council's Children and young people's services.
- School nurses gave examples of when they had attended child protection meetings and liaised with the school safeguarding teams to protect children.
- There was a system to provide staff with supervision for managing a child protection caseload, in line with the National Health Visiting Core Service specification 2015/2016. The child protection supervisors provided support to staff engaged in child protection and safeguarding cases. Staff provided examples of when they received support to review and challenge a child protection case, which had been resolved and closed. The formal supervision took place every three months

for health visitors and every four months for school nurses. This enabled discussions about any concerning cases, review of child protection cases to ensure they were child focussed and the development and review of action plans to provide additional support to staff when needed. The child protection supervisors were also available for informal supervision or support whenever needed. This was in line with the policy.

- Newly qualified health visitors and school nurses received additional safeguarding training during their induction and preceptorship training. These included the safeguarding policies and procedures, threshold guidelines and referring guidelines for child protection cases.

Medicines

- School nurses provided an immunisation programme to children and young people within schools. A partner organisation within the Community Children's Health Partnership managed the vaccination programme and ordering the vaccinations. Bristol Community Health had sufficient assurance from the stock rotational system and the data log, which recorded vaccination temperatures, and indicated vaccinations were safe to use. School nurses carrying out the immunisation programme were knowledgeable about the guidelines and standard operating procedure for delivering safe immunisation to children. Staff had a copy of the guidelines available during the clinic.
- School nurses delivered vaccinations under a patient group direction. A patient group direction provides a legal framework, which allows registered nurses who have completed appropriate additional training, to supply and administer a specified medicine to a pre-defined group of patients. School nurses we spoke with confirmed they had completed the required training and any updates.
- Emergency medicines were available at schools during the immunisation programme to enable staff to respond in the event of a child having an adverse reaction to the immunisation. An emergency store of adrenaline was kept on site during immunisation clinics. The lead nurse and one other nurse checked this at the start of each immunisation session. All the immunisation nurses received yearly training in resuscitation and managing anaphylaxis (severe allergic reaction).

Environment and equipment

- Premises were secure and maintained the safety of children and young people using the service. There were systems to ensure staff and visitors signed in when entering and leaving the premises.
- The environment and facilities at the locations we visited were tidy, well maintained and suitable for children and young people. There were toys and small chairs available for children, colourful posters on the walls and artwork on the walls, produced by the local children.
- Therapy staff had access to equipment required for children and young people to help improve their function, mobility or support parents with activities of daily living, such as bathing. Different bases held a small stock of equipment but staff could also order equipment online, for pick up or delivery to the child's home. There were systems to enable therapy staff to purchase more expensive specialist equipment for children. We observed occupational therapy staff provided a mother with a bath seat to assist her with bathing her child.

Quality of records

- We checked 21 sets of children's records. They were legible, dated, signed and contained records of treatment sessions or appointments attended by the child. However, not all services held a complete copy of children's records or maintained an individual record for each child.
- Health visitors did not keep individual records for each child. Instead, one record contained information of all children under their care in one family. Each set of records contained individual charts or developmental reviews for each child, but the notes documented following each visit by the health visitors contained information about all the children. . If an agency required a copy of an individual child's case notes, this would breach the confidentiality of the other children in the family, due to all of the children's case notes being recorded on the same document. Health visitors told us the change to managing records per family, rather than by individual child, came about three years ago following feedback from a serious case review.
- The health visitors maintained an unusual filing system. Records were filed away under the youngest child's surname. There was potential for this system to

break down, for example if a new health visitor took over and did not know the surname of the youngest child in the family, if this differed from the child they were visiting. This was a risk of maintaining one set of records per family rather than for each individual child.

- Therapy staff did not maintain an integrated set of records for children seen by the different therapy teams or jointly during a treatment session, therefore documentation was duplicated. All therapy records were paper-based and each therapy service maintained an individual set of therapy records for the child. An integrated therapy record would enable professionals to maintain a complete contemporaneous record of all interventions in chronological order by different professionals.
- The speech and language service carried out a yearly audit of records to identify compliance with best practice guidelines regarding record keeping. The 2015 audit had identified areas of poor compliance, such as the lack of the child's name and NHS number on each loose page, the use of abbreviations and a lack of a clear working diagnosis. The audit contained evidence of how each action had been completed and implemented.
- The physiotherapy service had completed a review of five sets of each individual therapist's records in 2016. There had been no further work to audit the findings to identify any themes or trends regarding record keeping or any learning, which may have come from the records review.
- The therapy teams maintained detailed records regarding the care and treatment they provided to children and their families.
- Speech and language therapists completed detailed assessments of communication, behaviour or nutrition.
- There was inconsistent use and completion of information contributing to the personal child health record or the 'red book', which health visitors completed. This was used by healthcare professionals to keep track of a child's health and progress, by recording important information about the child's health. Health professionals shared the book and used it as a tool to record significant events, such as illness, accidents or medicines the child may take. The 'red book' enabled all professionals involved with the child and the family to be aware of what was happening with the child and their development. We saw red books where information was incomplete, for example, the new baby review, a child's weight, family history or details of smokers in the household.
- The school nurses did not hold a complete set of records for each child. The records held by the school nurses did not contain detail of the child's medical history, and other interventions from other healthcare professionals since birth. There was inconsistent adherence to the guidance set out for the transfer of records to the school nursing team by the health visitors. Some records included a transfer report from the health visiting service, details of family events such as admission to emergency departments or screening clinics and referrals to other professionals or letters from other professionals following clinic appointments the child had attended. The transfer of only part of the child's record was not in line with guidance from the Royal college of Nursing, which recommends that a child should have a complete set of records.
- The different teams secured patient records within their office bases. Records were stored in filing cabinets and locked at night. The school nursing team had a filing system, which enabled easy access to records and when in use, a tracking system clearly identified where the records were.
- The school nurse records contained a narrative regarding the care and treatment provided at each contact or advice given by telephone to parents or schools.
- The school nurses held drop in clinics for young people to attend in each secondary school. Staff made a record of each young person's attendance at the clinic and the reason for their visit. Records were then transferred to the young person's electronic medical records and the original notes recorded during the consultation were destroyed. However, the Records Management Code of Practice for Health and Social Care 2016 defines a clinical record such as the ones made by the nurses, 'a predefined record that needs to be kept,' according to the organisations retention policy. The code of practice states, the retention period for children's records made by school nurses is the child's 25th or 26th birthday.
- A full review of a child's record was undertaken when a police protection order was issued. Under Section 46 of the Children Act 1989, the police have the power to remove children to a safe location for up to 72 hours to

protect them from 'significant harm'. This enabled an objective review of the care and treatment provided to the child and family to ensure this had been appropriate and to identify areas for improvement. Learning from the records reviews was cascaded across teams to reduce the risk of the same issues reoccurring. The information was cascaded through email briefings, team meetings and through one to one supervision.

Cleanliness, infection control and hygiene

- The service did not have reliable systems to ensure the protection of children and young people from the spread of infection.
- Not all clinics we visited had foot pedal-operated bins in the east locality. We observed health visitors touching bin lids to dispose of waste and not washing their hands or applying hand gel after doing this.
- Staff seemed unaware of the risk of infection and cross contamination. Health visiting staff covered scales with a padded absorbent sheet and then used blue paper over the top of the sheet to weigh babies. After weighing the babies, only the blue sheet was disposed of, but not the sheet that lined the scales, despite the babies coming into contact with the sheet due to them moving around. We also observed staff using the same tape measure moving from child to child without cleaning it between use.
- We observed poor infection, prevention and control practice with regard to hand washing and the cleaning of equipment at various bases. Staff did not wash or gel their hands between each child. We observed staff using the same set of scales for all children in one session, without cleaning it between each child using it.
- There were no systems or processes to provide assurance of toy cleaning following their use in treatment sessions. We saw staff cleaning equipment and plastic toys used during clinics or treatment sessions; however, no records were maintained to demonstrate cleaning had taken place. We did observe staff cleaning scales and plastic toys with disinfectant wipes or in hot soapy water after some sessions. At one joint therapy session we attended, each child who attended the group had their own box with the toys they used at the session. Once the child had used the toy, this would then remain in their box and be used by the individual child for the duration of time they attended the group. There had been no monthly audits completed to monitor the decontamination and cleaning of toys, as outlined in the toy cleaning policy.
- There were fabric/soft toys available for children to play with during sessions; however, this was not in line with the toy policy. There was no frequent, cleaning system to ensure fabric or soft toys were cleaned after use or any risk assessment available about the use of soft toys and cleaning them for children's treatment sessions. We saw collections of toys made from fabric and materials, which could not be cleaned with a disinfectant wipe following use. None of the toys was visibly dirty or stained, but staff showed a lack of awareness of infection control risks associated with not cleaning these toys. Staff told us that a member of staff in the department took the toys home each term and washed them. Different children used the toys during treatment sessions, thereby increasing the risk of spread of infection. The 'Cleaning and Decontamination of Toys' policy used by the service was an old policy from the previous provider, which was out of date and had not been reviewed since 2014. The policy stated, "Soft toys should not be kept for general use in clinical areas because they are porous, support microbial growth and can be difficult to decontaminate." However, we saw no evidence that any children had come to any harm due to the lack of compliance with the toy policy. Some of the changing mats were old and damaged. The damaged mats made it difficult to ensure they could be cleaned thoroughly after use to stop the spread of infection. Staff told us they had asked for new changing mats; however, these had not been replaced.
- The immunisation nurses followed appropriate hand hygiene procedures. We observed the nurses using hand gel to decontaminate their hands between each child. All staff were bare below the elbow.

Mandatory training

- The transfer of children's service to Bristol Community Health in April 2016 had caused difficulties in relation to the maintenance of accurate mandatory training records. Data relating to mandatory training was either lost or did not transfer across correctly, leaving the service unaware of what training each individual staff member had completed and when they were due for an update. Staff reported there were still challenges

with the system holding the data about mandatory training, with training staff had recently completed not showing up on the system. The provider's target was 90% compliance with mandatory training and there was an improvement plan to achieve this target. Poor compliance with mandatory training was recorded as risk on the service risk register and had been escalated to appear on the corporate risk register.

- At the time of our inspection, data provided by the service showed 70% compliance with mandatory training in October 2016, meaning not all staff were up to date with their skills and knowledge of safe systems to enable them to care for children and young people appropriately. The organisation provided a programme of mandatory training for staff, which included basic life support, infection, prevention and control, clinical governance, health safety and risk training, fire safety, moving and handling and Mental Capacity Act awareness training. Training was provided either face- to-face or via e learning.
- Staff expressed mixed opinions about the quality of the mandatory training. Some staff we spoke with felt since the move to Bristol Community Health, training had improved and was more applicable to community working. However, some staff we spoke with disagreed with this view, for example, some staff felt the online infection control training was not specific enough for their role and did not include the importance of cleaning toys.

Assessing and responding to patient risk

- Staff assessed and monitored risks and completed action plans to mitigate risks. Staff completed risk assessments and these were and kept in the child's record. These included any home environmental risks and any associated risks with family members. We saw evidence of completed risk assessments in children's records and actions to mitigate the risks. For example, we saw a completed risk assessment about a mother who had displayed volatile behaviour towards staff, where safety measures had been implemented, for example, by ensuring that staff visited in pairs if the child and mother could not attend a clinic. We saw evidence of a verbal handover, which took place regarding the risk associated with the child and family, when a child transferred between health visiting teams.
- There were systems and processes for staff to follow when children and young people did not attend appointments to ensure their safety and welfare. The safeguarding children policy outlined a clear flow chart for health visitors and school nurses staff to follow in this situation. The policy contained detailed information as to the procedure to follow if a child failed to attend an appointment, how to manage families who disengaged and how to monitor the situation. The policy also contained specific letter templates for staff to use.
- There was no consistent process for managing information sent to the school nursing team about the admission of a child to the local emergency department or urgent care centre. One school nurse told us it was their professional judgement, which determined any action taken. We reviewed one report with this nurse and they planned to contact the parents and the school to follow up the visit to the emergency department. Another nurse told us they were responsible for faxing the information to the child's GP. However, all staff we spoke with stated they reviewed each emergency department report and would take action if they suspected there were any safeguarding issues the child was at risk from. An audit had taken place in June 2015 to monitor the effectiveness of information sharing between services when children had attended accident and emergency departments. Recommendations from this audit were to clarify the process with local GP's and clarify the roles and responsibilities of staff regarding information sharing. At the time of our inspection, the audit for 2016 was taking place.

Staffing levels and caseload

- The children and young people's service employed a variety of staff, including school nurses, health visitors and therapy staff of various skill mix to ensure safe care and treatment of children and young people. However, not all teams used caseload-weighting tools to determine and monitor caseloads. Due to high demands for the children and young people's service and staff shortages due to, vacancies, sickness and challenges to cover absences using bank staff, the service was under pressure. In addition, due to

organisational structure changes when services were taken over by Bristol Community Health, the school nursing team lost clinical leadership roles to support staff in the different localities.

- The data provided by the organisation did not provide an accurate picture of the staffing levels, numbers of bank staff used and vacancies across the different disciplines working for the children and young people's service. However, in September 2016, the children and young people's service had an overall vacancy rate of 8.5% and a sickness rate of 4.2% for all staff disciplines across the service. There was also a high staff turnover of 14.9% in the children and young people's service in September 2016. The organisation acknowledged there were staffing shortages and pressures. Staff told us they too were feeling the pressures, but worked together to support their team and colleagues.
- In September 2016, the children and young people's services needed to fill 74 shifts with bank staff. Data provided did not identify whether these shifts were to cover one particular discipline or whether they covered a range of disciplines. Out of the 74 shifts, the service only managed to get cover for eight of the shifts. The organisation had recognised that there were issues with under-reporting of the need and use of bank staff which had been highlighted to the school nursing and health visiting leads who had acknowledged this needed to be improved moving forwards. At the time of our inspection, there was no plan of how this would be achieved.
- The children and young people's service employed 62 school nurses and 200 health visitors, all managed by the lead public health nurse. School nurse clinical lead band seven roles had been removed from the organisational structure, following the transition of services to Bristol Community Health in April 2016. This had increased the pressure on the public health lead nurse to manage all of the 62 school nursing staff.
- Health visitor caseloads varied between the different locations within each locality. We saw data from September 2016, demonstrating some health visitors were managing individual caseloads of between 154 to 542 children. Some of the health vising staff, particularly in the north locality, were managing caseloads, which were above the average level of 250 children, as recommended by the Royal College of Nursing. The health visiting leads recognised the issues with regard to staffing and capacity in the north locality where maternity leave and long-term sickness levels were high. The health visiting leads had developed a system to keep track of funded caseload sizes compared with actual caseload sizes. The leads told us this was helping them to plan where recruitment was necessary and how best to support the teams.
- There was no clear mechanism for monitoring and overseeing the allocation of caseloads. Individual therapists were aware of their own caseloads and had developed spreadsheets to identify their caseloads. The head of speech and language therapy was aware of area-based caseloads, rather than individual caseloads. However, once every three months the service reviewed all caseloads by monitoring the number of children and number of session's individual therapists were running. We were provided with examples of when caseloads were reconfigured to spread caseload equally between staff.
- School nurses were allocated a portfolio of schools within a geographical area; however, staff we spoke with were not aware of a tool used to determine the caseload for each member of staff. This meant that school nurses did not have an evenly distributed workload. Staff told us their caseloads were discussed at team meetings and colleagues assisted where they could.
- A caseload-weighting tool was used by the physiotherapy team to monitor individual staff caseloads. Treatment times were based on suggested evidence-based treatment guidelines. We saw the electronic system where information was collected regarding each individual referral allocated to each individual member of staff. The clinical lead reviewed caseloads every six months, with the aim being to have these reviewed more regularly at staff clinical supervision.
- Each speech and language therapist held an independent caseload based on national guidance. Each therapist held six to eight children from the early years on their caseload and saw between eight and 10 children during a clinic. The speech and language therapists were carrying caseloads larger than the recommended national guidelines. The team did not use a formal tool to determine caseload sizes and allocation was based on capacity in the different locations.

Requires improvement

Are services safe?

- The operational service manager monitored work carried out by the bilingual assistant practitioners; however, this did not capture the broad spectrum of work they carried out. There had been no audit completed to identify the varied work carried out by the bilingual assistant practitioners to determine how valuable they were to the service. The bilingual assistant practitioners were employed to work with the allied health professionals, physiotherapists, occupational therapists and speech and language therapists. These staff also carried out translation work for school nurses and health visitors by providing translation services over the telephone. We observed data captured identifying the work carried out for the allied health professionals however; this did not include the work carried out for school nurses and health visitors. Therefore, data captured did not fully represent the variety of work taken on by the bilingual practitioners.
- Health visitors felt the activities captured on their diary sheet did not reflect work carried out when it was inputted to the electronic system by administration staff. For example, there was a code to represent interaction with a vulnerable family under the universal partnership with children under two years of age; however, there was no code to capture the information for children who were over two years of age.

Managing anticipated risks

- There were systems staff followed to manage anticipated risks and systems available to alert staff to any known risks about the child or family.
- The electronic patient record system used a flag system to identify any concerns with individual families, which could put staff at risk when visiting. Staff identified and managed risks and worked together to mitigate risks ensuring the child's safety. Staff told us if they had any concerns about a child or their family, they would not visit alone. Instead, they would try to get the child and family to attend a clinic, or if this were not possible, they would visit with a colleague.
- Staff completed action plans to mitigate risks following risk assessments carried out on the child and facility. We observed completed action plans identifying plans to manage situations safely. Staff told us they would carry out visits together if there were concerns or try to encourage the family to bring the child to clinics for appointments.

Major incident awareness and training

- The Community Children's Health Partnership had a winter management plan used by all organisations making up the partnership. The plan described contingencies to be deployed to ensure the provision of effective services to clients by re-deployment of staff as required, maintaining cover and capacity for child protection and safeguarding, keeping staff safe in the event of circumstances or events, such as adverse weather conditions or a loss of amenities, for example, water. Each event had action plans associated with the event and a named person or team responsible for managing the actions.

Requires improvement

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

Overall we rated the effectiveness of children and young people's service as requires improvement because:

- There were challenges with the information technology system, which had affected the service, with regard to loss of mandatory training data and the loss of work, for example reports completed and saved on the information technology system by staff.
- A small number of the school nurses running the school drop in clinics at specific sites, were not competent to provide advice about contraceptives and sexual health issues.
- There was no formal procedure to support the transition of children from children's services into adult services.
- There were challenges with the Child Information Service, with records being delayed and being sent to the wrong health visitor base.
- Not all staff had a performance appraisal within the last year.
- There were no audits carried out on the single point of entry system to determine the effectiveness of the system, despite the risks of the paper-based referral system acknowledged by the management team.
- There were inconsistencies with the information passed to the school nursing team when a child transitioned to the service.
- The immunisation programme did not reflect the principles of Gillick competence.

However:

- Policies, pathways and treatment guidelines were developed in line with the National Institute for Health and Care Excellence guidelines and evidence-based practice.
- The service was delivered in line with the requirements set out in the Department of Health's Healthy Child Programme.
- Staff were supported to develop their knowledge and skills.
- There was good multidisciplinary working between teams and external agencies.

Detailed findings

Evidence based care and treatment

- Policies, guidelines and pathways had been developed in line with national guidance and evidence based guidelines. These included National Institute for Health and Care Excellence (NICE) guidelines and The Royal College of Paediatrics and Child Health.
- The children and young people's service was delivered in line with requirements set out by the Department of Health's Healthy Child Programme. This included early intervention, developmental reviews, screening, prevention of obesity, and promotion of breast-feeding.
- The service had achieved accreditation under the UNICEF baby friendly initiative, which championed evidence-based practice to promote and support breast-feeding. Staff were able to support young mothers to recognise the importance of breast feeding, make informed choices and enable them to continue breast feeding for as long as they wished.
- Caseload weighting tools used by the physiotherapy service were based on NICE guidelines and recommendations for treatment.
- Care pathways were developed and audited in accordance with NICE guidelines and reviewed by the multi-professional clinical effectiveness group. The service worked with a children's charity that carried out evidence-based pathway audits. Each audit took two years to complete, with the most recent being the Autism Spectrum Disorder in April 2016 and the Developmental Coordination Disorder pathway in July 2016.
- The Bristol care pathway for Children's weight management and Alive and Kicking programme were developed in accordance with NICE Institute of Health and Clinical Excellence Obesity guidelines.

Pain relief

- Staff discussed pain with children who were receiving immunisations. The immunisation nurses advised young people about pain in their arm being a potential

side effect following the immunisation. The young people we spoke with told us the nurse had told them what to expect regarding any pain or soreness and how best to manage this.

Nutrition and hydration

- Health visitors and school nurses provided information to parents and families about infant-led weaning and diet and nutrition. We observed discussions taking place during care and treatment sessions and staff providing advice and reassurance to parents and families. Staff had access to information leaflets to give to parents and children about diet and nutrition.

Technology and telemedicine

- There was very limited access to technology to support effective delivery of the children and young people's service. Staff and senior management team described the service as "paper heavy," with referral systems and records being paper-based. Bristol Community Health had only taken on the children and young people's service six months ago as part of a 12 months interim contract. The services had tendered to take on the long-term contract, but were yet to find out whether they had been awarded this contract. The Bristol Community health executive team was aware of the inefficiencies of the paper-based system and recognised there was a potential for error. We were told the electronic records and referral systems would be looked into if the contact were awarded long-term. Subsequently, since our inspection, the service had been awarded the long-term contract and assured us these issues would be addressed to manage potential risks.
- Staff had read-only access to an electronic system, which contained information about each child, what level treatment they were receiving, whether they were on a child protection plan or any risks in relation to the child's family or environment. Staff were unable to edit any information on this system, with only administrative and clerical staff having the ability to makes changes as required
- There had been challenges with the information technology systems since the transfer of services to Bristol Community Health in April 2016. Mandatory training data had been lost during the transfer and staff had to access the IT systems by having to log in via two different systems. Staff told us IT remained a big issue, with saved information repeatedly being lost. Staff gave us examples of reports they had written and saved on the IT system, which had been lost when they returned to work on them and training not being logged correctly or at all. Staff told us this was time-consuming and frustrating, however, they told us the IT support team was always very helpful. Despite the on going problems with the IT system, this was not on the children and young people's risk register.

Patient outcomes

- Information about the outcomes of children and young people's care and treatment was routinely collected; however, there was not a systematic approach to auditing the quality of the service and the outcomes for children and young people. Bristol Community Health had only been providing services as part of the Community Children's Health Partnership for six months, as part of a 12-month interim contract. The focus in this interim year had been to ensure a smooth transition of the service and to provide continued and undisrupted delivery of services to children, young people and their families.
- The service was monitoring the requirements of the Healthy Child Programme. This is a programme of screening tests, immunisation, developmental reviews, and information and guidance to support parenting and healthy choices. The programme set targets and performance indicators for services to meet.
- The therapy services routinely set and monitored goals for treatment with children and young people. The therapists used the Goal Attainment Scale (GAS) to monitor children and young people's outcomes. Specific goals were tailored to the individual child, which were then subject to an individual time period for completion but was scored by therapists in a standardised way. We saw complete GAS outcomes from the different therapy professions. Parents told us they had been involved with setting the goals for their child and had been part of the review process to see what their child had achieved within the time period.
- The health visiting teams monitored a child's outcomes using the Ages and Stages questionnaire. This was completed by parents to monitor their child's development and highlight any concerns and was completed at various times between one month and five years old. We saw completed questionnaires for

children under the health visiting team and action plans, developed jointly by the health visitor, family and the child to address any concerns highlighted from the review in relation to the child's development.
- The physiotherapy service had put in a bid to get access to a database to input clinical data for children with cerebral palsy. The Cerebral Palsy Integrated Pathway (CPIP) aim was to standardise the assessment of hips in children with cerebral palsy. The database would identify if the child's function or movement had deteriorated, which would enable earlier referral onto a specialist if required.

Competent staff

- Staff had the knowledge and skills required to carry out their role and were proactive in their desire to learn and develop their skills. However, not all staff had had a recent performance appraisal within the last year where discussions had taken place about performance or career development.
- The health visiting staff had attended a training day to develop their knowledge and skills around antenatal care. The health visitors were committed to embed and improve antenatal contact into their key schedule of visits, as recommended by the Healthy Child Programme. They had attended further training led by a nationally renowned psychologist in antenatal care.
- Not all staff had received a recent performance appraisal in the last 12 months. Between April 2016 and October 2016, 69% of staff had received an appraisal. Poor compliance with staff appraisal was not on the service risk register. However, we did see evidence of appraisals completed for some staff, which contained documented information of performance and actions to develop their knowledge and skills over the next year.
- The speech and language therapists used feedback from service users and colleagues regarding the care and treatment they had provided as part of their appraisal process. The feedback was discussed during their appraisal to identify areas of learning to improve performance.
- The physiotherapy team held a journal review club where the latest evidence-based practice was reviewed and critically appraised. The therapists discussed how beneficial it would be for children and young people accessing the service and whether or not it would be useful to trial the treatment in practice.
- The physiotherapy staff carried out monthly continuing professional development (CPD) sessions to improve their knowledge and skills in different areas of their practice. We saw the yearly programme for CPD training with the current theme being new equipment, which saw an external representative from a company come to demonstrate and discuss new equipment available.
- The physiotherapy team had recently recruited several new band six members of staff who were keen to develop their knowledge and skills, in order to become more confident and competent in their role. We saw the training matrix developed by the physiotherapy staff identifying core knowledge and skills and specialist knowledge and skills required for the role. A discussion about the matrix was held at the physiotherapy team meeting where the team discussed developing the matrix further and the delivery of the training.
- Integrated therapy technicians trained in physiotherapy, occupational therapy and speech and language therapy provided treatment to children under the supervision of the lead therapist to work towards achieving the child's goals. The technicians rotated to work with the different therapy teams every six months to maintain their competency and skills in all areas of therapy.
- The service had introduced a yearly peer review process to the different professional teams. Staff critically appraised each other's performance in practice. Completed peer reviews identified learning and actions taken from the process and staff had written self-reflections following the process. We saw an information sheet, which clearly set out the aims and objectives of the peer review and identified each person's role to ensure consistency and effectiveness between the different teams and professions. Staff told us they had found the process useful and a good way to reflect on their current practice.
- Each team of school nurses had a representative who attended a professional forum about the work plans for the service. Topics discussed at the forum included the Healthy Child Programme and the immunisation programme. The representatives then cascaded this information back to their teams.
- Newly qualified speech and language therapists followed a competency framework developed by the Royal College of Speech and Language Therapists, which was in place for one year after qualifying. A peer support group was in operation for newly qualified and junior staff.

Requires improvement

Are services effective?

- The school nurses attended an annual refresher course regarding the c card scheme (a scheme that provided children and young people, ages 13 to 24 with free condoms), to ensure they were up to date with the most current knowledge and information.
- A small number of school nurses carrying out school drop in clinics at specific sites, were not competent to provide certain advice to children. Some of the school nurses provided a drop in clinics in schools where there was a contraceptive and sexual health (CASH) clinic, run by one of the other partnership organisations part of the Community Children's Health Partnership. School nurses were not required to provide contraception advice or services. However, in the small number of schools where there was no CASH clinic, nurses could be required to advise children about contraception and sexual health issues, but they would not provide contraception. In this instance, nurses would signpost children to other local services to access contraceptives. However, we saw no evidence of any up to date specialist training in sexual health for these nurses who this applied to, with the exception of the annual C card update for the school nurses.
- Newly qualified health visitors and school nurses received a preceptorship programme of training to build their skills, knowledge and competencies. There were training sessions for the preceptors to attend in areas such as safety, policies, documentation and legal reports.
- The health visiting service leads had attended an external course to develop their skills and leadership qualities.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary team working occurred regularly between teams to ensure the most effective care and treatment for children and young people. Staff worked professionally and cooperatively between disciplines and organisations to ensure care was coordinated to meet the needs of children and young people. Staff told us they were most proud of their multidisciplinary working and described how they worked closely together to benefit the child and to ensure the child was at the heart of what they did.
- All referrals into the children and young people's service went through a single point of entry system. The system was predominately paper-based, however referrals were entered onto an electronic system to identify the date of receipt at the single point of access and to which team the referral was passed onto. Once a referral had been sent, there was no process to check it had been received administration staff we spoke with told us they would call to check the referral had been received. Therefore, no one would be aware of a referral had not arrived with the appropriate team. There were no audits carried out one the single point of entry system to demonstrate its effectiveness. The executive management team for Bristol Community Health was aware of the risks of the paper-based system however, this was not on the service risk register.
- Therapy teams worked together to ensure care was coordinated to meet the needs of the child. Therapy staff held a weekly multidisciplinary team meeting where they were able to discuss care and treatment for children with complex needs who were under the care of multiple therapists. This enabled the teams to understand how the child was developing in other areas. The meeting also enabled professionals to discuss any concerns about a child and effective working, to optimise development and achieve the child's goals.
- Health visiting teams and school nurses worked in daily partnership with external professionals and agencies. These partnerships included GPs, social services, schools and midwives.
- Health visitors and nursery nurses worked together to provide advice and support to new mothers at baby clinics.
- School nurses worked with the school teachers to improve their knowledge and skills to enable them to look after children with complex needs more confidently. The teachers had highlighted to the school nurses the requirement for training around managing and looking after a child with epilepsy and the use of medical devices for injecting a measured dose of adrenaline. We saw the training pack put together by the school nurses for the teachers to support the teaching session.
- School nurses worked in conjunction with Bristol City Council to tackle obesity among schoolchildren. The school nursing assistants worked with the council to deliver the Alive and Kicking Programme, a programme to deliver healthy lifestyles programmes to children aged two to 16 years who were overweight. A 10-week

workshop was held for families focusing on topics such as activity and exercise and healthy eating. Children were given child friendly leaflets about healthy eating; however, these leaflets were only provided in English.

- The organisation was working to address the challenges around communication, to enable a more seamless and coordinated care pathway on transition of a child from the midwives to the health visitors. Health visitors told us issues were around timely information sharing about new baby reviews, which had led to late visits and missed performance indicators. Health visitors provided us with examples of visits they had attended without the discharge paperwork from the midwives. Staff had raised this issue to the health vising leads who had advised staff to wait for the information, as it was essential to be fully aware of the child and family situation before they made the initial visit to the child. In July 2015, a quality assurance audit about the transfer of safeguarding information from midwives to health visitors was completed. One of the actions arising from this audit was for team briefings to highlight the importance of robust information sharing. We saw evidence of on-going work between the health visiting leads and the acute trusts responsible, to improve communication and promote more timely information sharing.
- The physiotherapists reviewed the joint range of all children under their care yearly, from two years of age, to support paediatricians with their yearly review of the child. The therapists completed an assessment of the child's function, joint range of movement and muscle tone, and a copy of the assessment was sent to the medical notes for other professionals, including paediatricians, to access. The yearly assessment enabled professional's comparisons year on year as to the child's progress, to help inform assessment and treatments.
- The school nurses provided us with examples of where they liaised with other professionals involved with young people. We heard how the pastoral support team at the school provided information to the school nurses and how, with the young person's consent, the counselling service discussed ongoing issues.
- The school nurses worked effectively with nurses from another organisations part of the Community Children's Health Partnership to provide a programme of immunisation to young people in schools.
- School nurses provided us with examples of when they had worked with school safeguarding teams to protect children.

Referral, transfer, discharge and transition

- There were inconsistencies between the school nurses regarding referrals accepted into the service and inconsistencies with information shared between teams during transition between services. There was no clear process for transition of children into adult services.
- Children and young people were discharged when they no longer required intervention. We observed a therapy session when a child was discharged from the service. The parents were reassured and advised about how they could continue with to work with their child at home and provided with information about how to get in contact with the service or to re-refer if this was required in the future.
- There was a standard operating procedure for managing the event where a child did not attend an appointment. Staff referred to, and could locate on the intranet, the procedure to follow when a child did not attend an appointment. The interim safeguarding children policy contained a clear flow chart outlining the process to follow when children did not attend appointments.
- There were referral criteria for the school nursing service; however, it appeared the school nurses were not always following guidelines with regard to accepting or declining referrals to the service. We attended a locality-wide, school nurse cluster meeting, where new referrals were discussed. There were inconsistencies with reasoning as to why some children were accepted and some declined. For example, one child was returned, due to there being no consent identified on the referral form, whilst another child was accepted, despite a lack of consent. However, nurses did follow protocol for accepting and prioritising a child into the service who was on a child protection plan. School nurses had brought this to the attention of the public health clinical lead during our inspection, who planned to investigate the issue further.
- There were inconsistencies with the information sent to the school nursing team from the health visitors when a child transitioned between teams. There was a policy available, which identified set documents that should be transferred to the school nursing team. On discussion with health visitors across the various bases, we found inconsistencies with what information was transferred;

therefore, the school nurses did not have a complete record and history of the child. Information not passed onto the school nurses was archived. However, the Royal College of Nursing guidelines state on transition between services, children should be transferred with a complete set of case notes to provide professionals with a detailed chronology of the history of events for the individual child.

- There were no standard operating procedures or guidelines to support transition from children into adult services, however, there were guidelines to support the transition of a child from the health visiting team to the school nursing teams. The health visiting teams had access to these guidelines in the guidelines for delivering the Healthy child Programme. Other teams would do their best to make transition as simple as possible for the child and family. The physiotherapy team provided a transfer form and a copy the most recent assessment and clinic letters. They would discuss the child ready for transition with the adult team prior to this happening. They would then aim to provide a joint session between the adult and children's service to make the transition easier for the child and family. This was currently happening for 50% of children who transitioned to adult physiotherapy services.
- The service had produced a child friendly information leaflet for children to help them understand what transition to adult services would entail. Children at a local school had produced the leaflet with the support of a children's charity. The leaflet also contained other information about other agencies and services children could contact for more support.
- The speech and language therapy service provided to primary age children in mainstream school. There was no service provision for secondary school age children in mainstream school. Children with additional needs who attended schools for children with special needs were provided with a service and during transition speech and language therapists liaised with and provided a written report to the adult speech therapy team.
- The school nurses referred young people who required access to contraceptives or sexual health information, other than the c card, to external agencies. The C card is a national scheme, which enabled children and young people aged 13 to 24 years of age to obtain free condoms. We saw the school nurses had contact details and clinic times available to give young people. However, the school nurses told us that they would provide advice and support about contraception and sexual health services to young people who attended the school drop in clinic if there was no contraceptive and sexual health clinic available. We saw no evidence of specialist training to demonstrate their competence to carry out this activity.

Access to information

- Some health visitors faced challenges accessing some children's records. The health visiting service had recently carried out changes to caseload management. Caseloads were now allocated within specific geographical areas, rather than the previous arrangement of caseloads being allocated in line with GP surgeries. This was in line with national guidance. Health visitors told us the Children's Health Information Service (CHIS) had also recently relocated to a different region and the issues combined had caused children's records to be delayed or sent to the wrong place. This affected the health visitors' ability to meet key performance indicators and caused a delay in families receiving support. We were told that there was regular communication between the Child Health Information Managers and the Senior Clinical lead on behalf of the Community Children's Health Programme to facilitate the changes, with issues being managed as they occurred. Despite this, staff we spoke with told us there was still a lack of clarity around some of the new set boundaries. These issues were not on the children and young people's risk register.
- The speech and language therapy team prepared patients' medical records prior to carrying out an assessment. This ensured they had all available information regarding the child. We observed an assessment and reviewed the patient's medical records. We saw there were letters from other professionals involved in the child's care and information from the health professional who had referred the child.
- The school nurses did not have access to young people's previous care and treatment records when providing a drop in clinic. Nurses we spoke with told us if they required additional information when at a school, they would ring their office, where administration or nursing colleagues would be able to review records to support them.
- School nurses did not appear to be using information available to them to inform them of a child's medical

history. There was a lot of repetition and discussion around the child's details, background and medical history at appointments with the school nurses. Parents had visited the service to access support and advice on issues such as continence. We observed sessions, where a large part covered information, which the school nurses already had access to in the child's notes. We observed parents' frustration at the amount of time this process took, which meant less time could be spent discussing the actual reason they had attended the clinic.

- The school nurses had information leaflets available for young people regarding relevant topics. For example, immunisations, panic and anxiety attacks, smoking, drugs and alcohol and healthy eating.

Consent

- The school nurses obtained written consent from parents, children and young people and kept this in the child's medical records.
- Parents received written information on the healthy screening programmes taking place in schools. The information provided them with the opportunity to opt out of this programme and if they did not return the letter opting out the service, it was assumed, consent had been given. We observed written consent had been obtained for screening the child's height and weight, on each set of medical records we looked at.
- There were no processes to inform parents when children had declined to consent to be screened. School nurses discussed the action which would be taken should a child refuse to be weighed or have their height measured. The nurses were clear the child would not be screened, but told us no letter would be sent to the parents advising of this. There was no process to follow up the screening. The Department of Health guidelines on seeking consent when working with children states it is good practice to involve the parent in the child's decision making unless the child specifically requests to not involve the parents, unless, the nurse felt the child was at risk of harm.
- A written consent form was required from a parent or guardian, prior to immunising children and young people. Consent letters were sent home with children and young people, to be completed by parents. The school nurses did not immunise any child or young person who did not have written parental consent. Under the patient group direction and the immunisation guidelines for the service, children were required to have a consent form signed by their parental guardian; however, there was no reference to Gillick competence and the child's right to consent. Gillick competence is a term used in medical law to describe the process used to determine whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Good

Are services caring?

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

Summary

We rated the caring of children, young people's and families services as good because:

- Staff showed compassion and treated children, young people and families with dignity and respect.
- Staff recognised children as individuals.
- Staff consistently encouraged and supported children and young people.
- Staff understood the importance of involving parents and families in goal setting and treatments.
- Parents and families were encouraged to ask questions to ensure they understood how the care and treatment benefitted their child.
- Patients we spoke with reported how staff supported them emotionally and often asked after their mental wellbeing.

However:

- Privacy and dignity of children and young people was not maintained at the immunisation clinic.

Detailed findings

Compassionate care

- During our inspection, we observed staff treated children young people and families with dignity, compassion and respect. Many of the families we spoke with told us they felt both themselves and their children were consistently treated with dignity and respect.
- Staff interacted with children in a respectful and considerate manner. During our inspection, we observed staff interacting with children, young people and families. Staff were considerate and polite. They recognised when the child did not want to engage or complete an activity and adapted or changed the activity to ensure the child did not become upset or distressed.
- Staff respected and recognised each child as an individual. We observed outstanding caring from staff who were singing a song to each individual child and addressing them using their name when they entered the room for their therapy session. These children had profound needs, and we recognised how their faces lit up when they came into the session and had their special song.
- Staff demonstrated an encouraging and supportive attitude towards children and young people. We observed staff during physiotherapy, occupational therapy, and speech and language therapy treatment sessions continually providing praise and encouragement to the children when they completed an activity. Staff we spoke with told us it was important to give the children positive encouragement, even if they were unable to complete the task correctly, to help improve confidence and encourage engagement with the task at future sessions.
- Most services ensured privacy and dignity for children and young people during physical, intimate care or during treatment sessions. Staff always kept the doors of assessment and treatment room closed during sessions. However, this was not the case at the immunisation clinic. There were five tables, with only two tables separated by screens. Both boys and girls were being immunised in the same area and young people with long sleeve shirts having to remove one arm from their shirt. The only cover they had was their blazer or a large sheet of blue roll to cover themselves. We asked the nurses about the set up and privacy for young people having to open their shirts. They told us "this was the way things had always been set up."
- Staff took the time to talk to children in an age appropriate manner they could understand. We observed staff using sign language to engage with children who had communication difficulties.
- Families and carers of children and young people provided consistent positive feedback about the service. One parent told us "staff are so supportive and helpful," "staff are always there when you need them," while another told us "staff are really friendly, helpful and always welcoming." Another mother told us '"the service is brilliant, couldn't have asked for a better one."
- We observed a speech and language therapist carry out a health assessment. They showed empathy, understanding and kindness towards the child.

Good

Are services caring?

- All of the young people we spoke with, who had received an immunisation, told us the nurses had been “friendly” and “nice” and had asked how they were feeling.

Understanding and involvement of patients and those close to them

- Staff understood the importance of involving families and carers of children and young people as partners in their care.
- Staff understood the importance of explaining their role and how their input could help the child to develop. Staff explained what they were doing and why they were carrying out a specific activity during sessions with children and their families. We observed staff taking the time to explain to parents what they were doing and why, during treatment sessions. This helped to engage the parent with the treatment because they understood the purpose of the activity.
- We observed staff providing information to parents regarding their children and the planned course of care and treatment. Staff spoke in a way which parents were able to understand and encouraged them to ask questions when they did not.
- Staff routinely involved families and carers in developing care plans for their child. We observed sessions with children and their families where goals were set and care plans were developed, containing the individual child’s goals for treatment. Parents and carers we spoke with told us they had been involved with developing care plans and setting goals but felt comfortable letting the member of staff lead on this as they knew how best to help their child.
- Staff recognised families and carers as being integral to the success of therapy sessions. We observed allied health professional staff, giving activities to families and carers and demonstrating the task to enable parents to continue working with their child at home. Staff provided families and carers with written information and the tools they required to be able to carry out the tasks at home to support their child with their treatment in order to help achieve goals.
- Families and carers were encouraged to ask questions in order to be involved with their child's care. We observed staff giving parents time and encouragement to ask questions about any care or treatment provided. We also observed staff explaining to children and young people what they were doing and why to help engagement with the task.
- Staff were aware of the different family set up and care arrangements for the children they looked after. We observed staff discussing the different options of help available with families and carers to ensure they felt supported and knew there was access to help if required. We observed staff talking to a child’s grandparents, who were their main carers, about how they were managing at home. They offered them a family support assessment and discussed options of care packages to provide further support and assistance at home.
- Staff understood the importance of promoting health and wellbeing of parents and families. We observed staff providing advice and information about parents receiving the winter flu vaccine to ensure they remained well over the winter months.
- Parents and families were encouraged to plan for the longer term to ensure they were organised and ready to cope with changes. For example, we observed a member of staff advising parents how to look into getting free school meals for their child.
- Staff interacted with children, spoke in an appropriate manner and repeated information to ensure the understanding of the child.
- We observed one interaction between a speech and language therapist and two parents. The therapist engaged the parents, gathered information from them about their child and provided guidance and information regarding the assessment process and the involvement of other professionals. We saw the parents were encouraged to ask questions and were given written information after the consultation. There was an open invitation to contact the therapist about anything they did not understand following the session.
- The immunisation nurses understood the importance of explaining to young people what they were doing during the immunisation process to relieve any anxiety or apprehension about the procedure.

Emotional support

- Parents we spoke with told us they felt emotionally supported by staff.
- Staff supported families caring for children with complex needs. One mother told us, when she was going through

a difficult time emotionally, staff were supportive. They had taken her aside and spent time reassuring her, which she had appreciated. Another parent told us "staff sorted me out when I was depressed," while another said, "I've had some issues - the health visitor has been great."

- Parents we spoke with told us staff always asked after their mental well-being.
- Group therapy sessions supported parents and families emotionally. Parents who attended a joint physiotherapy and occupational therapy session for parents and children with complex needs told us they valued the support from the other parents who attended the group and it helped knowing they were not alone.
- During every session we observed, all of the children were smiling and happy. If a child became upset or distressed, the staff would stop the activity or try to change the approach to the activity. For example, one mother told us her daughter became very upset when she had to use a piece of equipment during a therapy session. The staff tried the same piece of equipment in different sizes and colours to support the child to engage. When this did not work, staff continued to trial different ways to overcome the child's anxiety and came up with a solution, which resulted in the child using this piece of equipment during sessions.
- Families and parents were empowered and supported to maximise their child's health wellbeing and independence at home. We observed staff encouraging parents to continue working with their children between sessions to help optimise their chance of success to achieve their goals.
- Staff from different disciplines worked together to support the child and the parents emotionally during treatment sessions. We observed a joint physiotherapy and occupational therapy session for a child with complex needs, where the early years support worker for the child also attended. The early years support worker spent the session listening, talking and providing support and advice to the mother.
- Staff took the time to listen to parents and families. Parents we spoke with told us staff took the time to listen to them and always provided helpful advice.
- Staff provided further information where parents and families could get more support. For example, we observed a health visitor inform a father there was a monthly group held for fathers on a Saturday.
- We observed a session with a Somalian mother and child where the mother was clearly anxious due to her child having developmental issues. In order to support the mother, an assistant practitioner was asked to join the session to provide additional support to the mother with explanations and to support her with any concerns and anxieties.
- The immunisation nurses recognised when a child was anxious and worked with the child to provide support and reassurance to have the vaccination. The nurses took their time to explain the procedure and used different techniques to help calm and reassure the young person.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated the responsiveness of children and young people's service as requires improvement because:

- The service had not met performance targets for new birth visits or child developmental reviews.
- The occupational therapy and speech and language therapy service were not meeting the organisations referral to treatment targets.
- There were challenges to accessing the interpreter services.
- Consent forms were only provided to children in English, despite the fact that in one school the majority of children came from non-English speaking backgrounds.

However:

- Services were delivered in locally accessible areas and aimed to provide minimal disruption to children and young people.
- Parents' and families' feedback was gathered to help plan and deliver services to meet the needs of the local community.
- There were two bilingual therapy assistants, who could work with families whose first language was not English, to improve engagement with services.
- Groups were available to support the large Somalian community.

Detailed findings

Planning and delivering services which meet people's needs

- Staff were committed to delivering care as close to home as possible, which helped to minimise disruption for children, young people and their families. Staff visited children and young people in their own home, local clinics, schools and children's centres. We observed staff being creative during each session to ensure children engaged with the session to ensure the most effective use of time.
- The service used the Joint Strategic Needs Assessment to help plan and deliver services. The local priorities were dental health and giving out dental packs at nine to 12 months and breast-feeding, monitored by the health visitors. At the time of our inspection, the service was looking at ways in which they could more effectively deliver on the areas of priority, by allocating specific priorities to the operational service managers, however, this was in the early stages of planning.
- The health visiting team tried to maintain continuity for the families using the service. If a mother had another child, the team tried their best to allocate the health visitor looking after the siblings to the new child. This enabled better continuity and stronger relationships with the family to benefit the children.
- The therapy leads were keen to get the views of parents and families to help develop the integrated therapy service. Two feedback groups at the end of November and start of December 2016 were taking place for parents and families to attend, to discuss what they felt worked well and not so well regarding the therapy services. The clinical therapy leads planned to use the information to understand what the service users felt worked well and how they could most effectively deliver the integrated therapy service in line with the needs of the local population.
- The school nurses discussed the allocation of schools within teams. One example where a school for children with sensory needs had been reallocated to the caseload of the school nurses who supported children at schools for children with special needs. This was to utilise the additional skills and competencies of these nurses to benefit the children at the school.
- The school nurses provided a drop in clinic at each secondary school. These took place over the lunchtime, once a week. We visited one clinic but no young people attended. The school nurse had not seen any young people at the weekly clinic between September and November 2016. The school nurses told us engagement with the service was also dependent upon how the school promoted the service, and the children's awareness of how the nurses could support them, which differed between schools. Participation workers from a children's charity were currently liaising with young people to identify what they would require from the service and how to make it more young person friendly. The results of this engagement were not available at the time of our inspection.

Are services responsive to people's needs?

- The school nurses publicised the drop in clinics by displaying posters and providing information for the school to include in newsletters and send to young people by email.
- The immunisation programme followed a three-week programme to ensure all children and young people were immunised.
- There had been recent recruitment of a health visitor to work with the local traveller communities. The new role aimed to help break down barriers with families from this community accessing the service and to help engage them with local services and help increase the uptake with breast-feeding.

Equality and diversity

- There was inconsistent access to arrangements to meet the culturally diverse needs of local people.
- Health visitors in all localities faced challenges to accessing interpreters for children, young people and their families who attended clinics. Health visitors had discussed access to interpreting services at the health visitor team meeting. Staff had decided to book children in in advance if they required a translator, to allow time to arrange the service. We saw health visitors trying to book interpreting services to support families at clinics up to two weeks in advance, with a response from the translation team stating there was no availability or a lack of any response. We saw staff having to use a support worker to translate during one session, using a mobile phone translation application belonging to a mother during another session, while another health visitor had used a family's 11-year-old daughter to translate during a session. The NHS England Interpretation Policy states, using under the age of 16 for interpreting is not acceptable under any circumstance, other than when immediate and necessary treatment is required. Staff told us they felt poor access to a translating service was causing delays in children being seen and the provision of a good service for children and their families.
- The therapy services had two bilingual assistant practitioners who could act as translators or work with children and families where English was not the first language.
- There were support groups for families from the Somalian community whose children had a diagnosis of autism. The bilingual assistant practitioners ran this group monthly to provide support and advice to Somalian children and families with the diagnosis, to help overcome anxiety associated with the condition in this particular community.
- The service had recognised the need to have information printed in different languages to help children and families whose first language was not English to engage with the service. We saw information provided to children and families by the staff. For example, leaflets about conditions providing information written in other languages and posters on the wall at a baby clinic in Somalian publicising and recognising post-natal depression. However, staff recognised that translation of some information was not appropriate, as in some communities; there was less emphasis on reading written material, and more on talking and discussion.
- Staff completed equality and diversity training as part of their mandatory training every three years.
- The consent forms and associated written information were only available in English. Staff told us 75% of the children and young people in one school, in which the school nurses carried out an immunisation programme, came from non-English speaking families.

Meeting the needs of people in vulnerable circumstances

- Group therapy sessions were tailored to meet the needs of vulnerable and children with complex needs. This ensured the needs of the individual child with complex needs were met and therapy sessions were engaging for both the child and parent. There was flexibility within the group, to adapt the activity plan to the needs of the individual children attending. The therapists reviewed and updated every term. We observed the basic plan, covered during the session, for example joint range of movement, seated positioning and standing. During the group, we observed how staff worked one to one with the children and their families to tailor the activity to the child's individual ability.
- Staff working within the children and young people's service accommodated to the needs of children with communication difficulties. We observed staff using basic Makaton to communicate with children during therapy sessions. Makaton is a language programme using signs and symbols to help people communicate.

- The health visiting service assessed all mothers for symptoms of post-natal depression. For mothers, whose first language was not English, pictorial information, was used to assess for post-natal depression to determine how best to support the mother.

Access to the right care at the right time

- The organisation was not meeting performance targets such as referral to treatment time, new born baby reviews and child developmental screening reviews.
- The occupational therapy and speech and language service were not meeting referral to treatment performance targets. From April to August 2016, 100% of children and young people were seen by the physiotherapy service within 18 weeks of the initial referral. However, the occupational therapy department only saw 75% of children and young people within 18 weeks of the initial referral, against the provider's target of 90%. June 2016 saw the worst performance, with only 53% of children seeing an occupational therapist (OT) within 18 weeks. The speech and language therapists had only seen 81% of children within 18 weeks of their referral, against a target of 90%. Performance indicators had not been achieved, due to sickness and maternity leave. However, the operational service manager told us, clinicians' data, regarding contact with children and young people was not up to date, as there had been a backlog in entering this on the system.
- We looked at performance data, where children did not attend (DNA) appointments. Both physiotherapy and occupational therapy were performing better than the provider's target DNA rate of 6%, whilst speech and language therapy (SALT) was falling below this target. Between April and August 2016 the physiotherapy service had seen a 3.8% DNA rate, occupational therapy had experienced a 5% DNA rate, whilst SALT had seen a 6.8% DNA rate. However, there had been a spike in DNAs in August 2016. Poor attendance coincided with the summer holidays.
- The provider had developed recovery plans to target areas of under performance against waiting time targets and DNA rates. We saw the action plan to improve referral to treatment waiting times for occupational therapy and SALT. The service had developed a number of work streams in accordance with the action plan. For example, the number of initial appointment slots to see children had increased, there were more triage appointments, and resource packs developed to assist parents in working with their children to reduce the need to see the speech and language therapists. Group sessions had recently started to enable therapists to see more than one patient at a time. Feedback received from parents, children and young people prior to commencing this initiative. The action plans contained a named individual responsible for the actions and a target date for implementation. We also observed the action plan to improve DNA rate within the SALT service to reduce this issue if the service was to continue following the interim year.
- The health visiting service was not meeting targets in relation to the provision of new birth visits and child development reviews. Between April and June 2016, just 50% of newborn visits were carried out within 14 days, against a target of 90%, while 84% of six to eight week reviews were carried out by eight weeks, against a target of 90%. Only 77% of 12-month reviews were taking place by 15 months, against a target of 90%, while 61% of the two to two and a half year reviews had taken place by age of two and a half. We saw the action plan to reconfigure the current workforce in line with the National Health Visiting Specification 2016/2017 in order to reach set targets. The time line for the implementation of actions were in the process of being agreed by the commissioners of the service at the time of our inspection.
- Breast-feeding was monitored as part of the Healthy Child Programme; however, targets to sustain breast-feeding following discharge from hospital were not being achieved. Breast feeding rates at the six to eight week review showed 31.3% of the babies visited were breast-fed. This was against the target of 40%. Rates for the period between April and June 2016 showed a monthly average of 448 mothers visited, with an average of only 140 babies breast-fed. The health visitors had faced challenges in receiving records and information regarding new baby reviews from the Children's Health Information Service. This service held all records for newborn babies and until recently was based at South Plaza. Records had been delayed, or had not reached the correct health-visiting base. Staff felt the Children's Health Information Service was not aware of the geographical restructure of the health visiting teams, which was the reason for the confusion with the records. They felt these factors had affected the low figures recorded about breast-feeding, represented on the health visiting performance indicators.

Requires improvement

Are services responsive to people's needs?

- The school nurses had seen 94% of children and young people within eight weeks of referral in the reporting period April to August 2016.
- Records of children referred to the school nursing and service received their appointment was within the 18-week referral to treatment indicator. However, during one clinic one parent had needed to cancel their appointment the day before due to unforeseen circumstances. The school nurse told us there would be no other available appointment for a further six to eight weeks. This meant the child would have waited up to a minimum of 22 weeks for their appointment. We discussed this with the operations manager who assured us the earliest convenient appointment would be provided for the child.
- The SALT teams carried out home visits to pre-school age children with complex needs, such as eating and drinking difficulties. Generally, the service was provided within school or early year settings.
- The school nurses held drop in clinics at every secondary school. The nurses had access within the school to information leaflets regarding specific topics and information for young people on how to access other appropriate services, for example, the sexual health clinic or counselling services. The school nurses signposted or referred young people to these services when necessary.

Learning from complaints and concerns

- People's complaints and concerns were listened to and used to improve the quality of care.
- Parents and carers using the service knew how to make a complaint and felt they could raise any concerns with the clinical staff. Information on how to make a complaint was displayed in the clinics we visited.
- Despite the Community Children's Health Partnership being a consortium of three providers, it was the responsibility of the provider involved with the child to oversee any investigation and response to the complaint. This ensured continuity for the complainant.
- The children's service had five complaints between the July and September 2016. We reviewed these complaints and saw no trends. Complaints had been investigated, with complainants receiving a timely response, explanation and apology, where appropriate. Investigations also identified learning taken from the complaints and associated actions.
- Clinical service leads investigated complaints about the service. The service's clinical leads held records of complaints and these were taken to quarterly governance meetings for discussion.
- The operational service manager met individually with the clinical team leads from physiotherapy, occupational therapy and speech and language therapy on a monthly basis to discuss any complaints regarding each service.

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

Overall we rated the leadership of the children and young people's service as requires improvement because:

- There were disjointed operational processes, with different systems and processes to follow between the different organisations in the Community Children's Health Partnership.
- Senior leaders did not attend meetings where quality and performance were discussed.
- There were limited processes, such as clinical audit, to monitor quality.
- The risk register did not contain all of the risks associated with the service.
- Not all staff had a clear understanding of their role and accountability since the changes to roles and responsibilities in April 2016.
- The school nursing team did not have adequate team leadership to support staff.
- The school nursing team's lone working systems and processes did not ensure their safety.

However:

- There were clear strategies and action plans to improve services.
- Managers were visible, approachable and supportive to staff.
- With the support of a children's charity, feedback from children young people and their families was captured and used to improve services.

Detailed findings

Service vision and strategy

- Bristol Community Health had produced a business strategy and action plan with the local clinical commissioning group when Bristol Community Health took over the interim contract, to provide children's services. The action plan aimed to address issues around clinical governance, targets, such as referral times, breast-feeding, key performance indicators, school nursing and the speech and language therapy transformation plan. The aim was to be compliant by August 2017. There were challenges to delivering the same service specifications across Bristol and South Gloucestershire, with the different funding allocations to the areas. Bristol Community Health met regularly with the clinical commissioning group to review progress against all of the actions.
- Each individual service had its own business strategy action plan, outlining specific objectives and plans to improve the shortfalls recognised within each service. For example, there was an action plan to improve initial occupational therapy appointment waiting times in South Gloucestershire. The speech and language therapy service had a strategy and action plan to reduce waiting times for initial appointments and a plan to reduce non-attendance at appointments. There was a public health nursing recovery plan to improve the service's position and ability to deliver the five mandated developmental checks for children. All of the actions had a target date and had an allocated person responsible for overseeing the actions and completion of the outcomes. Action plans were regularly reviewed and updated.
- The commissioning arrangements presented challenges to the management of the three organisations managing children and young people's community services across the region. Whilst there were no effects on clinical service delivery, the operational systems were disjointed. For example, managers told us they managed and supported staff from two different organisations. This meant there were different forms, systems and processes to follow for administration processes, such as sickness recording, which were all paper-based. Senior leaders were working on an action plan to move all staff to the main corporate systems to align systems.
- There was an integrated, two-year review, project management plan with a strategy and objective to integrate the Early Years Foundation Stage statutory two-year-old reviews with the Health Child Programme developmental assessments. Reviews took place when a child was between 18 and 36 months old, by different professionals with separate frameworks. Integration of the health and education reviews would provide a more holistic approach to identifying how a child developed

and facilitate more effective intervention and support to reduce inequalities in children's overall outcomes. The integration programme was part of a multi-agency initiative between health, local authority early years teams and Bristol Children's centres. An integrated approach to working was being piloted in the Bristol locality in 2015 and was on going at the time of our inspection.

- A transformation plan was in place for the speech and language therapy service. The plan came from an external review carried out by the clinical commissioning group in 2014. The plan informed the current service specification and looked at working towards more efficient and effective service delivery. There was on going work looking at service delivery and the timeline for implementation. There were challenges delivering the plan, due to the different workforce numbers in Bristol and South Gloucestershire. Bristol Community Health was providing monthly updates and quarterly update reports to the clinical commissioning group regarding the progress of the plan.
- There was a vision to integrate the therapy services, to provide a more joined up way of working to benefit the child and to make better uses of staff, time and resources. The therapy clinical leads were overseeing the action plan and time-frame for implementation of the integrated therapy service and met every six weeks to review their progress against the action plan. The action plan looked at the approach required, partnership working, communication, service user engagement, administration processes and the workforce and identified timescales for implementation and action leads for each action.
- Speech and language therapy had reallocated existing resources across Bristol and South Gloucestershire. This had helped to improve service provision for children and young people and waiting times for children and young people.

Governance, risk management and quality measurement

- There was a clear structure for reporting within Bristol Community Health and the Community Children's Health Partnership.
- There was a governance framework for Bristol Community Health children's services, which fed into the Children's Community Health Partnership. There was regular reporting to the clinical governance where incidents, complaints, safeguarding, patient safety and performance targets were reviewed. We saw minutes from these meeting which demonstrated actions had been taken to address issues affecting the service, for example performance targets.
- Not all members of the leadership team attended in quality and performance meetings. This was due to the change in the organisation structure when services were transferred to Bristol Community Health in April 2016. Leaders with oversight of a locality had to find quality and performance information for themselves about their locality from minutes of meetings. Some of the staff in this position told us this was challenging, but felt the minutes of the meeting provided them with enough information so they had good oversight of the service they were managing. Work was on going to develop the roles and responsibilities of the leaders within the service.
- There were action plans and processes to monitor targets and key performance indicators; however, there were limited processes available, such as clinical audit, to monitor quality. The transition of the service to Bristol Community Health in April 2016, had presented challenges including, changes to people's roles, paper based work systems, and different systems and processes carried out by the different organisations in the Community Children's Health Partnership. The transition had also seen changes to ways of working, which compounded by information technology issues, loss of data and limited access to the IT system, which at the time of our inspection was on going.
- There was a comprehensive system to record and manage risks; however, not all risks to the service had been identified and recorded on the risk register. Risks which had been identified, were rated and had been allocated to a named person allocated to oversee the risk and action plan to mitigate the risk. Risks such as lone working, waiting times and funding for health visitors had been identified but there was no reference of the risk of under-reporting incidents, which had been discussed at September 2016 clinical governance meeting. Other risks not added to the risk register were, the transfer of health visitor records from the Children's Health Information Centre, IT issues, paper-based referral systems and appraisals. Poor compliance with mandatory training was not on the children's service risk register but had been escalated to the strategic risk register for Bristol Community Health.

Requires improvement

Are services well-led?

- There was no systematic programme of clinical or internal audit to monitor quality. We saw evidence in some areas, records had been reviewed, but there had been no further action taken to identify any themes or trends from the information or action plans to address these. However, we saw evidence of the speech and language service monitoring the quality of care provided to patients by reviewing medical records and case notes. Case note review outcomes were discussed at team meetings to share learning.
- The service was monitoring performance targets and there was evidence to demonstrate performance issues were being addressed. We observed action plans for the occupational therapy, speech and language therapy and health visiting teams to address issues such as attendance rates, referral to treatment times and national key performance indicators for health visiting teams. Action logs were clear, with each action having a designated person responsible for the actions and their implementation within a specific time-frame. Actions were regularly reviewed and updated.
- Staff reported their daily activity using a paper-based system. Data clerks entered the information onto the electronic database. We saw team leaders remind staff at meetings to ensure more timely completion of diary sheets. Staff were also concerned the activity data recorded did not represent the work they were actually doing. Therefore, the activity data was not always up to date and did not provide an accurate reflection of the work programmes. There were also issues across the different teams with ensuring diary sheets were completed in a timely way and passed to the administration team to log onto the system.
- The operational service manager met on a one to one basis with team leaders from physiotherapy, occupational therapy and speech and language therapy each month. This enabled monitoring of annual leave, sickness, governance, incidents and complaints to take place.

Leadership of this service

- Not all senior leaders had a clear understanding of their role, responsibilities and accountability within the service. There were three operational service managers for children and young people across the Bristol localities; however, there were inconsistencies with their understanding of their role and responsibilities. There had been many changes to roles and responsibilities during the transition of services in April 2016, leaving some staff unclear of their role. We saw evidence of staff working to clarify this. We heard a discussion at the monthly allied health professional leads meeting about this issue and saw evidence of an on going piece of work centred on the roles and responsibilities of senior members of staff. The aim of the work was to ensure lines of accountability were clear to all members of staff.
- Senior managers were visible and approachable. Staff we spoke with spoke highly of their managers and felt they could go discuss concerns or anxieties. Staff told us they felt their leaders were supportive.
- The leadership and management structure for the children and young people's service had undergone a transformation period. The current arrangements were interim for the period of one year. The restructuring was on going but all staff we spoke with were clear this had not affected the services provided to the children and young people. Parents and families also told us there had been no disruption to services since the transition.
- Under these arrangements, there were 23 health visitor bases and seven school nurse bases. From these bases worked 62 school nurses and 200 health visitors, who were managed by the lead public health nurse. There were three band seven clinical managers for the health visiting staff but no additional senior management for the school nurses. Staff told us there had previously been band seven school nurses in post, but these positions were no longer part of the new organisational structure during the transition of services to Bristol Community Health. It was challenging to manage a workforce of this size effectively and ensure regular supervision and appraisal.
- Band six school nurses supported the public health lead by providing line management to band four and five school nursing staff.
- Band six school nurses attended monthly operational meetings, to involve them in planning and decision making for the service.
- Information was provided to the public health clinical lead from individual teams, which included work pressures, safeguarding concerns, immunisation programme, sickness absence and any other critical information regarding the staff and teams. This kept the lead up-to-date with current issues within the service and any changes or actions that needed to be taken.

Are services well-led?

- The speech and language therapy service was split into two teams. One team was responsible for care and treatment for school age children and the other for pre-school age children. Both of these teams had a team leader to support the head of service.
- The children and young people's service lead felt there had been a lot of corporate support from Bristol Community Health to support with the transition and challenges this entailed.

Culture within this service

- Staff we spoke with across the different teams felt they worked for a service with an open culture and could discuss any issues concerning them. They told us line managers were approachable and responsive. Teams worked closely and communicated effectively ensuring, they worked together to provide an effective service for the child and to their family.
- Staff felt connected to the Community Children's Health Partnership (CCHP), more represented, and identifiable as a children and young person's service. Most of the staff we spoke with were positive about the transition of services to Bristol Community Health. They felt the CCHP had more of an understanding of community working and what this entailed. This was reflected in the training and the set-up of the service.
- All staff we spoke with were proud of their team and the way in which they worked together to support each other.
- Some staff told us how approachable the chief executive of the service was and how she operated an open door policy.
- The staff had gone through a significant period of reorganisation and change since April 2016. During this time, staff had continued to strive ensure the children and young people remained at the forefront and focus of the service. Parents and families told us they had not experienced any problems or noticed a change in the service, despite the transition.
- There was a lone working policy available for staff on the intranet; however, the approach to managing lone working varied between teams. Some teams used a board in their office where information was kept in one place; whilst other teams used their individual electronic diaries to document their visits, which their team leads had access to. School nurses we spoke with did not use electronic calendars but recorded their scheduled visits into their own diary. Unless colleagues had access to the diary, they were not aware of where the nurses were carrying out visits. This did not ensure their safety.
- The lone working policy detailed the use of a 'buddy system' to improve safety when staff worked alone. Staff operated an informal 'buddy system' where they contacted a colleague once they had left the premises of a family home. However, not all staff we spoke with followed the policy consistently.
- Lone working had been identified as a risk and was on the children and young person's service risk register. Not all staff had a work mobile phone to enable them to call for advice or assistance if required, in line with the policy. Since the transfer of services to Bristol Community Health, there had been a problem in obtaining sufficient numbers of mobile telephones. Managers told us the organisation within the Community Children's Health Partnership who had the responsibility for managing the IT systems did not have a contract with a mobile telephone provider.
- Staff provided the organisation with contact details of their next of kin or nominated family member or friend. This was so contact could be made should an incident occur when lone working or at work.

Public engagement

- The service worked in partnership with a children's charity on the Helping Young People Engage (HYPE) project. The key priorities of the project had been developed in partnership with commissioners, service users, and CCHP senior leaders and clinical services. The project aimed to address inequalities in health provision and to improve outcomes for all children, young people and their families by having the children's experience at the centre of the decision-making. We saw the annual work programme six-month review with on going actions to improve services, which allocated a named person to implement and monitor actions.
- The service was working with an external agency to develop a questionnaire for children young people and their families to support the audit process for therapy services. The aim was to produce the questionnaire in different languages to get a representative sample of the diverse culture of children young people treated by the service. The Picker Institute is an international charity who use people's experience of healthcare to identify priorities in delivering the highest care quality, by

working across health and social care systems to support organisations to improve the quality of patient care. At the time of our inspection, this work was still in its infancy.

- A children's charity assisted the organisation to gain feedback from children and young people. We saw child friendly questionnaires provided to children and families to collect feedback about the services. We were told the occupational therapy service had a low return rate of questionnaires and the physiotherapists a good return rate. The feedback had led to the production of a coordinated care leaflet to explain what this was and how it worked to children, young people and their families.
- The physiotherapists had organised a forum to discuss and review the services provided to patients. Young people were involved with the forum and invited to share their views. This resulted in the creation of an integrated therapy service, which provided a one-point contact for patients, reducing the number of appointments they were required to attend.
- Children and young people were regularly involved in the recruitment process for new staff. A children's charity supported the panel of children and young people to interview new members of staff, the most recent appointments being an operational service manager and the health visitor for the traveller community. The public health lead nurse told us the children's panel and opinion was highly valued and respected. On one occasion the children on the panel had not been satisfied with an applicant's answers at interview and felt children were not at the heart of their vision for the service. They had subsequently overturned the adult panel and the applicant was not recruited.
- Children, young people and families were involved in service planning and delivery. The service worked closely with a children's charity, which encouraged and supported children and their families to provide feedback about services. A quarterly report summarised feedback captured using the 'how to be heard' questionnaire and identified themes and trends and actions for the different services to enable them to improve the quality of the service provided. Children and young people had been involved in the design of the website for the service, production of child friendly information leaflets and had formed part of an interview panel to recruit staff.

Staff engagement

- Staff provided us with positive feedback following the transition to Bristol Community Health in April 2016. Staff told us they were all given an induction and given training and information about the local policies and where to find them. Staff told us they were reassured about the transition and received personal welcome cards from the chief executive of the service.
- Staff received weekly email news bulletins from the senior management team at Bristol Community Health. We saw the weekly bulletin for the week of 14 November 2016. This included updates on the tender for the long-term contract for the children and young people's service. Information was circulated about the up and coming clinical governance half days staff attended about updates or changes to policies and procedures.
- School nursing and health visiting staff had opportunities to meet with the public health clinical lead to share their views on the management and communication within the services. As a result of this, monthly meetings had been arranged to ensure effective communication channels between the staff and the organisation were in place
- A mini staff survey had been completed by staff in the community children and young people's service following the transition of services to Bristol Community Health. The survey had picked up some negative themes around lack of trust in senior management, lack of career progression opportunities, mixed uptake of clinical supervision and insufficient time to carry out their role effectively. At the time of our inspection, work was on going to develop an action plan to address these themes.

Innovation, improvement and sustainability

- The service had put forward a bid to purchase the Cerebral Palsy Integrated Pathway (CPIP) database for the South West to provide a standardised approach to care for children with cerebral palsy. The CPIP provided a high quality, standardised follow-up programme, of hip surveillance, for children with cerebral palsy. At the time of our inspection, the department was waiting to hear if the bid had been successful.
- The service was looking towards providing an integrated therapy service for children and young people to ensure effective use of time and to provide a more efficient service to children, young people and their families. At

Requires improvement

Are services well-led?

the time of our inspection, the clinical therapy leads had developed an action plan to work towards an integrated service. They were also engaging with service users to gain feedback on what they felt worked well in each of the therapy services so they could incorporate this into the integrated care model.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated; 12 (2) (i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. 12 (2) (h) There was no assurance of staff adhering to toy cleaning policies, rotas or schedules for the toys owned by the clinics used by Bristol Community Health staff. Staff were unaware of who oversaw the toy cleaning schedule and how often toys were cleaned. The staff were unaware of any risk assessment carried out to determine the rationale for toy cleaning, how toys were cleaned and how often. There was no frequent, robust cleaning system to ensure fabric toys were cleaned after use with children. We observed collections of toys, which were made from fabric, and materials, which could not be cleaned with a disinfectant wipe following use. None of the toys was dirty or stained but there was a lack of awareness of infection control risks of not cleaning these toys. We were told these toys were taken home termly by a member of staff in the department and cleaned. Toys like this were used by different children during treatment sessions increasing the risk of spread of infection. We observed poor infection, prevention and control practice with regard to hand washing and the cleaning of

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Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular to – (a) assess, monitor and improve the quality and safety of the services provided in the carrying out on of the regulated activity (including the quality of the experience of service users in receiving those services. (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of the service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect to each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; 17 (2) (a) There was no systematic programme of clinical or internal audit to monitor quality. We saw evidence in

equipment at various bases. Staff did not wash or gel their hands between each child. We observed staff use the same set of scales for all children in one session without cleaning it between each child using it.

12(2) (i)

There were no standard operating procedures or guidelines to support transition from children into adult services, with the exception of the transition of children from the health visiting to the school nursing service. Teams would do their best to make transition as simple as possible for the child and family.

Requirement notices

some areas, information had been captured such as reviewing records, but there had been no further action taken to identify any themes or trends from the information and or action plans to address these.

17 (2) (b)

There was a comprehensive system to record and manage risks; however, not all risks to the service had been identified and recorded on the risk register. Other risks not added to the risk register were, the transfer of health visitor records from the Children's Health Information Centre, IT issues, paper-based referral systems and appraisals.

17 (2) (c)

A complete set of children's notes was not transferred to the school nursing team on transition to the service.

Health visitors did not keep individual records for each child. Instead, one record contained information of all children under their care in one family. Each set of records contained individual charts or developmental reviews for each child, but the notes documented following each visit by the health visitors contained information about all the children. If an agency required a copy of an individual child's case notes, this would breach the confidentiality of the other children in the family, due to all of the children's case notes being recorded on the same document. Health visitors told us the change to managing records per family, rather than by individual child, came about three years ago following feedback from a serious case review.

The school nurses held drop in clinics for young people to attend in each secondary school. Staff made a record of each young person's attendance at the clinic and the reason for their visit. Records were then transferred to the young person's electronic medical records and the original notes recorded during the consultation were destroyed. However the Records Management Code of Practice for Health and Social Care 2016 defines a clinical

This section is primarily information for the provider

Requirement notices

record such as the ones made by the nurses, 'a predefined record that needs to be kept,' according to the organisations retention policy. The code of practice states, the retention period for the children's records made by school nurses is the child's 25th or 26th birthday.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (2) (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. 18 (2) (a) Not all staff had received a recent performance appraisal in the last 12 months. Between April 2016 and October 2016, 69% of staff had received an appraisal. Poor compliance with staff appraisal was not on the service risk register. At the time of our inspection, data provided by the service showed 70% compliance with mandatory training in October 2016, meaning not all staff were up to date with their skills and knowledge of safe systems to enable them to care for children and young people appropriately. Staff were not fully compliant with safeguarding training. In September 2016, 77% of staff had completed level one children's safeguarding training, whilst 81% had completed level three training. Staff also completed safeguarding adults training; with 82% having completed level one training, but only 46% of staff were complaint with level two adult safeguarding training. This was against the organisation's target of 90%.