The Newcastle upon Tyne Hospitals NHS Foundation Trust

RTD

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)
RTD03	Campus for Ageing and Vitality		NE4 6BE
RTD02	Royal Victoria Infirmary		NE1 4LP

This report describes our judgement of the quality of care provided within this core service by The Newcastle upon Tyne Hospitals NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by The Newcastle upon Tyne Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of The Newcastle upon Tyne Hospitals NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated this service as good overall because:

- Staff were aware of their responsibility to report incidents, they knew how to report incidents, near misses and accidents and were encouraged to do so. Learning from incidents was shared between teams and across the organisation.
- There were safeguarding systems in place to protect children from harm, although some staff in the health visiting and school nursing teams were not receiving recommended amounts of safeguarding supervision. There was a dedicated safeguarding team in place.
- Staff received mandatory training, although it was not clear whether all staff were up to date due to differences between recorded data held by the trust and individual practitioner's records.
- Staff received regular supervision and appraisals, although it was not clear whether some staff were up to date with their appraisal as figures provided by the trust indicated that they were not meeting the target for appraisals.
- The service had sufficient numbers of staff and had appropriate sized caseloads in line with national guidance.
- Care and treatment was evidence based with policies, procedures and pathways available to staff. There was good evidence of multi-disciplinary working and good transition arrangements were in place. Staff were aware of their responsibilities with regards to obtaining consent.
- We observed staff treating people with compassion, kindness, dignity and respect. Feedback from children, young people and their families was positive.
- Services were planned to meet people's needs and the needs of different people were taken in to account. There were systems in place to make sure that children, young people and their families could access care at the right time and services were flexible enough to fit in with individuals needs. There were examples of innovative practice that aimed to make the services more accessible to people such as those with a learning disability. Feeback from service users was taken in to consideration when developing services.
- Leaders were approachable, supportive and encouraged staff engagement. Staff knew the trust vision and values. Governance systems were in place to ensure delivery of good quality care.
- While most of the services had their own strategy, the community directorate strategy did not incorporate children's services within it.

Summary of findings

Background to the service

The children and young people's service covered any services provided to babies, children, young people and their families. This included services provided in a child's home, community clinics, drop in centres or schools. The services included:

- Universal health services and health promotion (such as health visiting and school nursing).
- The provision of family nurse partnership and looked after children's teams.
- Community nursery nursing and family health practitioners.
- Delivery and coordination of specialist or enhanced care and treatment. This included specialist nursing services, therapy services and community paediatric services. These services provided and coordinated care and treatment for children and young people with long-term conditions, disabilities, multiple or complex needs and children and families in vulnerable circumstances.
- Community sexual health services for people of all ages.

Children and young people under the age of 20 years make up 23.5% of the population of Newcastle upon Tyne. 25.6% of school children are from a minority ethnic group.

The health and wellbeing of children in Newcastle upon Tyne is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 27.4% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Children in Newcastle upon Tyne have worse than average levels of obesity: 11.6% of children aged 4-5 years and 23.2% of children aged 10-11 years are classified as obese.

We visited 11 different locations including well baby clinics and schools. We attended home visits with the health visitors and community children's nursing team. We spoke with 67 staff, 13 parents, three children and young people and one head teacher. We reviewed 17 sets of notes. Focus groups were held with the health visitors and school nurses, allied health professionals and community administration teams. Prior to and following our inspection we analysed information sent to us by a number of organisations such as the local commissioners, Healthwatch and the trust.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, Hospitals, Care Quality Commission

Head of inspection: Amanda Stanford, Care Quality Commission

The community children and young people's inspection team consisted of a CQC inspector, a community paediatrician, a health visitor, a school nurse and a paediatric occupational therapist.

Why we carried out this inspection

We inspected Community Health Services for Children, Young People and Families as part of our comprehensive inspection programme.

Summary of findings

How we carried out this inspection

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

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

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 from 19 to 22 January 2016. We spoke with members of staff and observed their practice in clinics, schools and homes. We spoke to young people and parents/carers. Records were reviewed.

What people who use the provider say

Children, young people and their carers all gave positive feedback. They felt they were listened to and treated with respect. Parents that we spoke with at baby clinics said they would recommend the service to their friends.

Good practice

- The paediatric nutrition team consisted of a gastroenterologist, surgeon, pharmacist, dietician and specialist nurse. This team saw a high number of home patents with very good results. Outcomes of success were demonstrated in a reduction in morbidity, mortality and decreased costs.
- The School Nursing Team offered 'pop-up' interactive health stalls in the school environment. This new approach had received national recognition winning the Cavell Nurses' Trust Award for School Nursing Innovation.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Ensure that health visitors and school nurses receive safeguarding supervision every three months and the safeguarding policy is amended to reflect this.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- There were systems in place for incident reporting and staff understood their responsibilities to raise concerns and report incidents. We heard examples of learning from incidents. There had been no recent serious incidents reported.
- There were arrangements in place to safeguard children from abuse with a safeguarding team in place to provide oversight. Safeguarding supervision was taking place but some practitioners were not having it at the recommended level of three monthly and the safeguarding policy did not reflect this recommendation. Staff were undertaking safeguarding training at the required level.
- Staffing levels and caseloads were appropriate and in line with national guidance. There were appropriate systems in place for assessing and responding to risk.
- Medicines management was good with systems in place to keep people safe.
- Staff received mandatory training although there was some discrepancy in the figures held by individual practitioners and those held by the trust.
- Records were accurate, legible and up to date. They were kept securely.
- There were some identified issues with the environment. The risk register highlighted some accommodation as not fit for purpose. Therapy services did not have a dedicated space to see children and families.

Safety performance

Good

Are services safe?

- The service had no reported never events or serious incidents between November 2014 and October 2015. Never events are serious, wholly preventable patient safety incidents which should not occur if proper preventative measures are in place.

Incident reporting, learning and improvement

- The service reported 59 incidents between November 2014 and October 2015. 95% of these incidents were reported as low or no harm. The most common incident was listed as 'documentation'.
- We heard examples of learning from incidents. Staff told us about a change in the policy for checking vaccine fridges after an incident with high fridge temperatures.
- Staff were encouraged to report incidents and all staff we spoke with were aware how to report incidents on the electronic reporting form.
- An up to date appropriate incident reporting policy was in place.
- Managers told us that incident action plans were discussed at cluster coordinator meetings and then fed back to staff. We saw minutes from the cluster coordinator meetings which showed evidence of action plans having been discussed.
- Learning from incidents across the trust as a whole was shared with teams. Clinical governance meetings were held monthly and directorates received incident reports. Staff told us they received feedback at team meetings and by email.
- Minutes from the clinical governance meetings were reviewed, and incidents and incident reporting were a standing item on the agenda.
- Staff we spoke with were aware of the Duty of Candour and the need to be open and honest with service users and their families. The trust had an up to date Being Open (Duty of Candour) policy.
- Staff we spoke with were able to give us examples of being open and honest with families. One health visitor told us of a family where there had been concerns about a child's speech, but a referral had not been made to speech therapy and the practitioners were open and honest with the parents about this.

Safeguarding

- The trust had an up to date safeguarding children policy which gave clear guidance to staff on their responsibilities, including procedures to follow for no access visits.
- The safeguarding team included a named doctor and named nurse which complied with the recommendation in Working Together to Safeguard Children (HM Government 2015).
- All staff we spoke to were aware of their own responsibilities and how to raise concerns. Staff were able to show us the flowchart used to assist them in the referral process or what they should do if they had concerns about a child or young person.
- The safeguarding team were accessible and staff told us they could contact the team at any time if they had concerns.
- The trust had a target of 95% for level one and level three safeguarding training. Figures provided by the trust showed that no services apart from the Family Nurse Partnership had achieved the target for level one and none of the services had achieved the target for level three. However, staff we spoke with told us they had attended the training and their individual record cards indicated this. Staff told us that the system for recording training does not always capture the right data as it does not recognise the hours for the training they have completed. The Trust's Safeguarding Annual Report highlighted the challenge in ensuring safeguarding mandatory training data was robust. Work was ongoing to ensure compliance data was accurate and that compliance with trust standards could be achieved.
- Health Visiting and School Health staff were receiving safeguarding supervision from the safeguarding team at least twice a year in line with the safeguarding supervision policy. However, this was not in line with the Health Visiting Service Specification 2015/2016 (NHS England) and Maximising the School Nursing Team Contribution to the Public Health of School-aged Children (DH 2014), which state that safeguarding supervision should be a minimum of three monthly.
- Staff told us that safeguarding supervision could be accessed at any time that a practitioner needed it and we saw evidence that some staff had safeguarding supervision more than twice a year.
- The Family Nurse Partnership nurses accessed safeguarding supervision every three months with the safeguarding named nurse and their supervisor.
- The sexual health service received safeguarding supervision four times a year where cases were discussed.

Good

Are services safe?

- The children's community nurses were offered safeguarding supervision three to four times a year.
- We saw evidence in the records we reviewed of safeguarding supervision having been documented.
- The SystmOne computer system used a flagging system to indicate if a child was subject to a child protection plan or was looked after. This meant that practitioners were aware on accessing a child's records if there were any safeguarding concerns.
- Records reviewed had evidence of comprehensive child protection reports completed and multi-disciplinary working to support the families was evident. Appropriate assessments had been undertaken and early help plans put in place where required. Appropriate communication and information sharing with other professionals was evident.
- The safeguarding children team and the looked after children team were co-located which meant that information could be shared easily between the teams.
- The trust had in place female genital mutilation (FGM) multi-agency practice guidance. All staff had training in FGM and the school health team were including FGM in their PHSE sessions in schools. Female genital mutilation (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK.
- Staff from the sexual health service had adapted a national proforma for recognition of child sexual exploitation (CSE), 'Spotting the signs' (2014), and were using it as an assessment tool for all young people under the age of 18. Child sexual exploitation (CSE) is a form of sexual abuse that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity.
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The health visiting service had a CQUIN goal for integrated working between health visitors and GP's after serious case reviews highlighted lack of communication as an issue to be addressed. Health visitors we spoke to said they attended GP meetings once a month to share information regarding families with more complex needs and safeguarding issues.

Medicines

- We observed arrangements for managing medicines that kept people safe. There was good maintenance of the cold chain. Cold chain refers to the process used for the safe transport, storage and handling of immunisations. Immunisations need to be kept within a certain temperature range from the point of manufacture to when they are used.
- Vaccines were only ordered when required and stored in a locked fridge.
- Procedures for managing a break in the cold chain were seen.
- We saw evidence of fridge temperatures, in the sexual health service and the school health service, having been regularly checked. Temperatures recorded were within limits.
- We saw the school health service's folder for refrigeration monitoring which contained an up to date Refrigeration of Medicines Policy, a fridge test certificate which indicated the fridge had been calibrated, a rota for monitoring the fridge temperature readings, completed fridge temperature readings and a sheet for recording vaccines taken out of and put in to the fridge.
- Cool bags with cool packs were used to transport vaccines to immunisation sessions. Staff told us that they monitored the temperature every hour at immunisation sessions.
- We saw medicines in the sexual health service stored in locked cabinets. Expiry dates were regularly checked and recorded.
- We saw evidence that patient group directives (PGD's) were in use and up to date. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor (or dentist).
- All health visitors were nurse prescribers. Managers told us that practitioners were updated by emails and forums that had specific nurse prescribing sessions. However, some staff told us that there was not a lot of refresher training and they had to keep themselves up to date. This may mean that health visitors are not maintaining their nurse prescribing skills.

Environment and equipment

- The community services risk register identified some community accommodation as not fit for purpose

which could impact on the staff. Staff at one base told us that the lighting did not work in the car park at the back of the building, and so for safety staff left the building in pairs.

- Physiotherapy staff told us that they did not have a dedicated space to see patients and had to find suitable venues. This created a challenge and they felt it had an impact on productivity if they were spending time trying to find venues. Each therapist is allocated a specific area to try to reduce this impact.
- Equipment seen in all locations had been portable appliance tested (PAT) and evidence was seen that scales were regularly calibrated.
- Staff told us that they had good access to equipment for those items that were in stock. Occupational therapists told us that for access to non-stock items an application was completed which went to the head of occupational therapy. This process could take around six to eight weeks. Independent funding requests for bespoke equipment went to the commissioners.
- All medical devices and equipment were logged on a database which ensured that equipment was serviced when required.
- Staff used an online system to record the medical devices they used and the training they had undertaken. Evidence was seen of training logs having been kept up to date.
- Therapy servicescarried out risk assessments for the venues they used for therapy. They did bespoke risk assessments on special beds that were used.

Quality of Records

- The 0-19 service used an electronic patient record called SystmOne. Staff could only access this when back at base as they did not have mobile devices. This meant they did not have access to the notes when on home visits or out of the office. Staff told us they ensured they had accessed the record prior to leaving the office and noted any important information.
- Therapy services used paper records and had limited use of SystmOne.
- We saw evidence of records having been kept securely in locked cabinets.
- Records we reviewed were accurate, legible and up to date in line with national guidance. We saw evidence of the voice of the child in the records.
- Seven out of the 17 notes we reviewed contained abbreviations without the word having been written in full the first time it was used. To support effective communication records should be written so that the meaning is clear to all who access them.
- We saw evidence of a record audit undertaken in November 2015 by the 0-19 service. This identified that 10.7% of records had the use of inappropriate abbreviations. The manager told us that staff had been informed of this and the plan was for staff to conduct a self-audit of records in the next few months.

Cleanliness, infection control and hygiene

- Premises we visited were visibly clean. We saw an up to date hand hygiene policy.
- We observed staff using appropriate hand hygiene techniques in clinic settings and on home visits. Bare below the elbows practice was adhered to.
- Toys were regularly cleaned. We saw records indicating this cleaning had taken place.
- We identified a concern in one of the schools where a paediatric clinic was held as there were no handwashing facilities in the room where patients were seen. The medical staff did not have any hand gel and had to exit the room to access washing facilities. This issue was raised with staff at the time of our inspection and their plan was to ensure staff carried hand gel with them to the clinic.
- We saw evidence that audits were regularly undertaken. The results of an audit done in September 2015 showed that teams had scored 100% for hand hygiene technique and infection prevention and control practice.
- Equipment cleaning records were seen. These showed that regular cleaning of equipment took place.

Mandatory training

- The trust had an in date mandatory training policy which contained a training matrix for core and role specific training required. Training available included infection control, information governance, fire safety and basic life support.
- Staff told us they had no problems accessing training and were given time to complete it.
- Mandatory training figures provided by the trust showed that training compliance in the community directorate

Good

Are services safe?

as a whole was 86.1% against a target of 95%. Actions were in place to ensure compliance with the trust target. Services were holding figures locally and managers were encouraging staff to complete their training.
- All staff we spoke with were up to date with their training and we saw evidence of this in their personal records.
- Role specific training was available such as maternal mental health training for the health visitors. Figures provided by the trust show that 100% had completed this training.

Assessing and responding to patient risk

- The safeguarding children policy contained guidance on what to do in the event of no access visits and missing children.
- We saw evidence in records of assessments undertaken using a common assessment framework. This allowed for early identification of additional needs.
- The Family Nurses told us that they always contacted the midwife when they received a referral to discuss any risks.
- Health visitors and school nurses told us that they met for a face to face handover on complex, vulnerable families.
- The service had a specialist health visitor for children with additional needs. Staff could access support from her when needed.
- The children's community nursing service included the Children's Acute Nursing Initiative (CANI) which operated seven days a week from 8am until 10pm. This team supported early discharge from hospital. If necessary, the nurses arranged for the child to be seen again by the medical team. Out of hours families were given the number for the on call registrar and had direct access back to the hospital if needed.
- The children's community nursing team and the Children's Acute Nursing Initiative (CANI) team had good links with paediatricians and the acute trust for medical attention if needed. They attended clinical skills courses and spent time on the paediatric assessment unit to ensure their skills in recognising a deteriorating child were up to date.
- The trust had a consultant in forensic paediatrics. Children were seen for child protection medicals in a separate unit adjacent to accident and emergency. Paediatricians had monthly peer review sessions and weekly forensic peer review.

Staffing levels and caseload

- The community children's services were well staffed.
- Figures provided by the trust showed that there were 89 whole time equivalent (WTE) health visiting staff in post against a budget for 98 WTE and 26 WTE school health nursing staff in post against a budget for 27 WTE. The service was actively recruiting to these vacancies.
- Other areas such as Family Nurse Partnership, sexual health services, community paediatric occupational therapy, community paediatric physiotherapy and community paediatric speech and language therapy were fully staffed.
- The community paediatricians worked 70% in the community and 30% in the acute trust. Feedback from the staff was that they felt a bit stretched, and they had written to the commissioners to ask for a WTE designated doctor for Special Educational Needs (SEND). At the time of our inspection the post of designated doctor for SEND was undertaken by an associate specialist. Management had listened to previous concerns and increased staff numbers.
- No weighting tool was used to assess health visitor caseloads. Staff told us they were looking at developing a tool. Caseloads were managed at workforce planning meetings by assessment of the local population and the number of complex families on a caseload. Staff's ability to carry out the core contacts was assessed and caseloads altered accordingly.
- Health visitors had a caseload of roughly 250 children per WTE health visitor. This was within the caseload limit of 400 recommended by Lord Laming in: "The Protection of Children in England: A Progress Report" (March 2009).
- The band 6 school nurses were allocated one secondary school each and the band 5 staff nurses were allocated primary schools, with supervision provided from a band 6 nurse. This was in line with staffing levels set out by the Royal College of Nursing guidance and the Department of Health white paper (Choosing Health, 2004).
- The children's community nursing team had 21 WTE qualified nurses, seven health care assistants and one play specialist. They had 1 WTE vacancies. This was in line with the RCN (2013) recommendations.
- The Family Nurse Partnership Core Model Elements recommend that family nurses should carry a caseload

Good

Are services safe?

of no more than 25 families per full time employee. The family nurses normally have a caseload of between 20 and 25 families. At the time of our inspection they had approximately 21 families each due to the complexity of the families.

- Figures from the trust showed that sickness rates for the community in June 2015 were 7%. This was above the trust average of 4%.

Managing anticipated risks

- The trust had a 'Maintaining Services during Adverse Weather Conditions and Public Transport Disruption' policy which set out the responsibility of the employee and managers.
- Staff had been provided with lone working devices, although they did not all use them. All staff managed their diaries on the computer system to indicate where they were. Staff signed in and out of bases.
- Visit were conducted in pairs if there was an identified risk.
- All staff conducting home visits carried mobile phones.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Care was provided in line with national guidance, such as National Institute for Clinical Excellence (NICE) guidelines. Staff had access to up to date policies, procedures and pathways.
- The service was providing the Healthy Child Programme (HCP), National Child Measurement Programme (NCMP) and Family Nurse Partnership (FNP) programme.
- Services were meeting outcome targets. There was an annual audit programme in place.
- Our observation of practice, review of records and discussion with staff confirmed effective multi-disciplinary team (MDT) working practices were in place. There were processes in place for referrals and transition. Staff were aware of their responsibilities with regards to obtaining consent.
- Staff had regular supervision and appraisals although it was unclear if all staff were up to date due to discrepancies in recording. Figures held centrally by the trust differed from those held by individual practitioners.
- The sexual health service used technology to engage with young people. Other services were looking at ways to increase their use of technology.
- Some services were using electronic records while others still used paper records. Those using electronic records did not have access to mobile working devices to enable them to accesss patient records at all times.

Evidence based care and treatment

- The policies, procedures and pathways we saw were up to date and evidence based. Staff had access to these on the trust intranet.
- We saw pathways for: antenatal communication between the community midwife and health visitor; promoting early attachment for all families to promote social and emotional wellbeing for babies, young children and their families; multi-agency maternal health; preschool obesity; a flow chart for the Family Nurse Partnership referrals and a pathway for the integrated health visitor 24 month review, which included the use of the Ages and Stages Questionnaire (ASQ). ASQ is an evidence based tool that helps to identify problems in children's development allowing for effective early intervention.
- Pathways in use by the children's community nursing service were seen for tracheostomies, oxygen therapy, gastrostomies and subcutaneous infusions.
- We saw evidence from the records that the services were effectively delivering the Healthy Child Programme (HCP). The HCP is an early intervention and prevention public health programme offered to every family and is an opportunity to identify families in need of further support.
- Practitioners were trained in and used the Solihull Approach. The Solihull Approach is an evidence based model that promotes emotional health and wellbeing in children and families.
- 10 health visitors were trained to deliver the Newborn Behavioural Observation – an interactive and family-centred tool designed to develop and foster positive parent-child relationships.
- Services had achieved UNICEF baby friendly stage 2 and were working towards stage 3.The UNICEF baby friendly initiative is a national intervention that has been found to have a positive effect on breastfeeding rates in the UK.
- The community paediatric team had identified that they did not have the resources to meet the NICE guidance for autism after initial diagnosis. The service had put in a business case in order to try to deliver the targets for autism.
- The trust had a Family Nurse Partnership (FNP) team which had been established in 2014 with the first clients recruited from April 2014. FNP is a voluntary health visiting programme for young and first time mothers. It is underpinned by internationally recognised evidence based practice.
- The trust had a looked after children team which provided extra support to children who were looked after based on the Department of Health document 'Promoting the health and wellbeing of looked after children' (2015).

Good

Are services effective?

- Therapy services used evidence based assessment tools. They followed NICE guidance in relation to autism and spasticity. We saw evidence in therapy services records of clear goals having been set for those children with more complex conditions.
- Children's community paediatrics and children's nurses held enuresis clinics with care and treatment delivered in line with NICE guidance.

Nutrition and hydration

- The 0-19 service had a health visitor who was the lead for infant feeding.
- Health visitors performed breastfeeding assessments at the primary birth visit.
- Body Mass Index measurements were assessed universally at 2yrs and then at 5yrs and 11yrs as part of the National Child Measurement Programme with children identified as being overweight and obese being referred to targeted services.

Technology and telemedicine

- The manager of the 0-19 service told us that that they were looking at ways of increasing their use of technology.
- The Family Nurse Partnership used texting as a primary form of contacting their clients.
- The chlamydia screening team based within the sexual health team had a website and a Facebook page which they used to inform young people about their services.
- The sexual health service provided negative test results to young people through text messages.
- The sexual health team were working on producing an app for young people to use to find the nearest place to them offering condoms.

Patient outcomes

- The health visiting teams were performing within target tolerance levels in relation to the Healthy Child Programme. Target tolerance levels for the birth visit and eight week visit were 85%, 12 month assessment and two to two and a half year assessment was 80%. Figures provided by the trust showed that 89% of birth visits were done between 10-14 days, 88% had a review by eight weeks, 85% had a 12 month assessment and 87% had a two to two and a half year assessment.
- The public health school nurses annual report 2014-2015 indicated that the school health service were meeting national averages for uptake of the HPV vaccine.
- The rates for babies breastfeeding at six weeks was 46% which was slightly above the England average of 45%.
- The Family Nurse Partnership quarterly summary report in September 2015 showed that in the last 12 months 60% of clients were enrolled before 16 weeks of pregnancy. This was in line with a goal of 60%.
- The community directorate had an audit programme in place for 2015/16. For example, the school health advisers had an audit to improve the uptake of immunisations with ethnic minorities. The health visiting service had an audit to improve health visitor's awareness of the Care of Next Infant (CONI) programme. The sexual health service had a reaudit of appropriate disposal of sharps following IUC fitting procedure. These were ongoing at the time of our inspection.
- Therapy services were working on a project looking at outcome measures.The results of the project were due in March 2016 and would inform implementation of routine outcome measurement, staff training and service delivery.
- School nurses were in the process of trialing routine outcome measures for goal setting and focusing interventions for PHSE sessions.

Competent staff

- Figures provided by the trust showed that all staff had a corporate induction.
- New staff to the trust had a preceptorship period. We spoke to a member of staff who had been at the trust three months. They felt well supported and had frequent supervision sessions with their manager.
- We saw a preceptorship framework for band 6 school nurses. Staff were given a minimum of six months to complete this.
- We saw a role development pack for band 5 children's community nurses which set out learning outcomes and competencies.
- Staff were able to access training relevant to their role, such as immunisation training and maternal mood training.
- Occupational therapy staff told us they are given opportunities to go to external events to keep up to date and competent.

Good

Are services effective?

- Staff told us they received clinical supervision four times a year. Record cards were seen that indicated this had taken place.
- The family nurses had weekly supervision and monthly psychology supervision.
- Figures provided by the trust indicated that the community directorate appraisal figures were at 75% against a target of 80%. Managers were monitoring appraisal figures and, when their appraisal was due, ensuring staff kept up to date by sending them reminders.
- Staff performance was managed through appraisals. Where poor staff performance was identified there was a capability policy that guided managers through a process to support the practitioner.
- There were five specialist health visitors in the service whose role was to support and educate staff; they could provide extra supervision to staff when required.
- We were told that all medical staff in community paediatrics had signed job plans, although we did not see them.
- One of the health visitors in the service was a Fellow of the national Institute of Health Visiting (iHV). The Fellowships are awarded in recognition of professional achievement and help identify a group of experts and inspirational leaders nationally.

Multi-disciplinary working and co-ordinated care pathways

- Staff from therapy services told us they had close links with the children's community nurses for those children with more complex needs. These staff groups were all based in the same building.
- Staff attended care meetings within schools.
- Staff in the different services attended Early Help meetings. An Early Help assessment is a standardised approach to assessing children and young people's needs and deciding how the family can be supported by the multi-disciplinary workforce.
- The community paediatric physiotherapists ran groups jointly with preschool workers.
- Health visitors attended GP monthly meetings to discuss more complex families.
- The specialist health visitors had good relationships with the local authority and had promoted their role within different agencies.
- Health visitors and school nurses attended weekly Early Help meetings which were attended by Early Help advisers, education advisers, a social worker for children with disabilities and the duty social work manager. At this meeting referrals and step down cases from social care were discussed to ensure that families have enough support in place.
- The looked after children team told us they had access to social care records which meant that consent for health needs assessments was obtained in a timely way.
- Health visitors worked with colleagues in Sure Start to provide support to families. Referrals were made to Sure Start workers and Sure Start workers could refer to the health visiting team.
- Each service had a clear referral pathway and referrals were discussed at regular meetings to ensure the children received the appropriate care.
- The school health team worked closely with the sexual health team. The school nurses had a health promotion stall at the Newcastle Pride event which was organised by the sexual health team.
- Staff told us they could contact the CAMHS team for advice. Referrals to CAMHS was normally a 13 week wait.
- We saw evidence in community paediatric notes of involvement of the multi-disciplinary team.
- Community paediatricians told us they had good communication with and access to the acute trust medical team.
- The children's community nurses had good links with the community paediatricians and the acute trust. The children's acute nursing initiative (CANI) team liaised effectively with the acute trust and could arrange readmission of a child if needed.
- The child health team were based with the 0-19 team which had proved beneficial for the sharing of information.

Referral, transfer, discharge and transition

- We saw core referral criteria for paediatric physiotherapy which gave priority bands, referral indicators, those where referral would not be indicated and the maximum time they should wait to be seen.
- Community paediatric occupational therapy had started accepting referrals for the under-fives in the last couple of months. Prior to this there was no service for the under-fives.
- Referral forms were seen for school nursing, speech and language therapy, physiotherapy, occupational therapy and the children's community nurses.

Good

Are services effective?

- Health visitors and school nurses could refer to community paediatrics if the GP was in agreement. The community paediatric service had allocation meetings every week where referrals were triaged by a consultant.
- The 0-19 service had developed a 'Hello/Goodbye' event for the transition from the health visiting service to the school nursing service. This event allowed children and their families to say hello to the school nurse and goodbye to the health visitor along with having their health and growth assessed.
- Health visitors told us they would conduct a face to face handover with the school nurses for those families with more complex needs.
- The community children's nurses linked with the GP for transition. All children with complex needs had a flag on the child health record. When the child reached 11 years old the GPwas sent a letter reminding them that they have a child on their caseload who was likely to need a complex discharge plan. The formal process of transition to adult services began at 14 years old when meetings with all relevant agencies took place so that health needs and transition arrangements were identified and a plan put in place.
- The looked after children team attended looked after reviews for those children with high vulnerabilities who were transitioning to adult services.

Access to information

- The community children's service did not have a fully integrated multi-disciplinary team case note record as some services used an electronic patient record, while others used paper records. This may mean practitioners do not have access to up to date information from other services.
- The 0-19 service used an electronic patient record. However, the service was not mobile working and did not have access to laptops or tablets to enable staff to access records while on visits, in schools or at meetings.
- Staff told us they would note down any relevant information before they went out of the office. Staff would record their activity on return to the office.
- The transfer of records from health visitors to school nurses was done on the electronic system which meant all the information needed for their ongoing care was shared.
- Community paediatrics and acute paediatrics used paper records. The records were integrated and staff at paediatric community clinics had access to the records.
- Staff in some of the baby clinics were having to input data on two different computer systems as the GP used a different system to the health visiting team.
- The sexual health service used paper records and were moving towards using an electronic patient record.
- The community services risk register highlighted the fact that young people accessing the different clinics within the sexual health service meant that multiple records could be produced which could lead to lack of continuity of care and the potential to miss child protection issues. The service had put controls in place so that they checked with service users regarding previous attendances. They were able to access cause for concern alerts at the main base.
- Some staff that were based in buildings not owned by the trust could not access the trust intranet and had to access this at other bases.

Consent

- Staff we spoke with were aware of Gillick competency and Fraser guidelines. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.
- We saw evidence in school nursing and children's community nursing notes that young people had been assessed for Gillick competency.
- We saw evidence of written consent having been obtained from parents for immunisations. Staff told us they then obtain verbal consent from the child before giving the immunisation.
- We saw evidence in records we reviewed of consent obtained for information sharing.
- The looked after children's team told us that if someone was assessed as lacking capacity to consent they would make best interest decisions. Where there was borderline capacity this was more difficult and there had recently been an issue around a parent's capacity to consent. This had made the team more aware of the need to assess parent's capacity as well as the childs. The team understood the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Good

Are services effective?

- Records we looked at for therapy services contained consent forms which were signed and dated. Consent was also recorded on the computer system. There was a paediatric risk assessment tool for making decisions around mental health.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff were observed to be caring and compassionate and were able to provide children, young people and their families with emotional support. School nurses provided bereavement support to children and families.
- Children, young people and their families were involved in their care. Community children's nurses ensured that families were involved with the planning and delivery of care.
- Children and families who used the services felt listened to. They told us that they felt supported and staff were approachable and helpful.
- Verbal feedback we received from parents and young people was positive.

Compassionate care

- We observed staff interacting with children and young people in a respectful and considerate manner.
- School health staff were observed showing an encouraging and supportive attitude to the young people that attended their sessions.
- We spoke to young people using the services. They felt the staff treated them with respect and they could talk to them.
- We spoke with parents who told us that staff were respectful and caring; they were approachable, friendly and gave good advice.
- The national Friends and Family Test data for community children's services was limited. We saw results for the children's community nursing service but only three responses had been received. All three responses were positive.
- You're welcome questionnaires and focus groups were held in schools to gain feedback. Comment cards seen gave positive comments.
- We saw 13 'Take two minutes' cards and all had positive comments about the staff.
- Young people at the sexual health clinic had their privacy and confidentiality respected by the use of registration cards which were filled in and handed to the reception desk.
- Care measure data provided by the trust from April 2015 showed that 718 out of 722 respondents rated the community paediatric physiotherapy service as fair to excellent at showing care and compassion. Two respondents felt they were poor and two had not replied.

Understanding and involvement of patients and those close to them

- We observed staff talking with the children and young people in a way they could understand.
- We spoke to young people at a school for children with challenging behaviour and learning issues who told us that the school nurse helped them and they had learnt about first aid, CPR, healthy eating and their bodies.
- We spoke to parents attending baby clinics who said they were happy with the information that had been provided by the health visiting team.
- The community children's nursing service employed a play specialist to provide additional support to children and their families.
- Children and their families were involved in the planning of their care. We saw evidence of this in records and parents we spoke with told us they felt involved.
- The community paediatric service routinely provided copies of clinic letters to families. It had been identified that there was a delay in typing letters due to problems with administration. In order to deal with this there was some restructuring taking place and appointment of new staff.
- The children's community nursing service developed care plans jointly with parents and the young person.

Emotional support

- We observed school nurses speaking to young people about their feelings and family relationships.
- School nurses gave time for the young people to discuss their concerns and gave young people the opportunity to be seen again.
- The community children's nursing service had a family support team. Health care assistants were able to provide support to families with children with complex needs providing respite or short break care.

Good

Are services caring?

- Staff provided emotional support to families after bereavement. The school nursing service provided group work in school around bereavement.
- Practitioners used motivational interviewing techniques in order to empower families to manage problems and difficulties.
- The sexual health service worked closely with Streetwise in the city which was a regional charity offering advice and counselling to young people.

Good

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 responsive as good because:

- Services were planned and delivered to meet people's needs. They acted on feedback received from service users to develop new ways of working that were beneficial to the families and young people.
- Services were offered at times and places to suit the needs of children, young people and their families.
- Services took into account the needs of different people, including those in vulnerable circumstances. Processes were in place to support children, young people and families from different ethnic backgrounds, those with hearing impairment and those from the lesbian, gay, bisexual and transgender (LGBT) community.
- Services were meeting targets for care and had minimal waiting times.

The children's community services received minimal complaints. Those they did receive were dealt with appropriately.

Planning and delivering services which meet people's needs

- The health visiting service held baby clinics in various locations across the city.
- There had been a move in some clinics from drop in to appointment sessions in response to feedback from parents about waiting times.
- The Hello/Goodbye transition events held by the health visitors and school nurses started in response to feedback from parents.
- The school nursing service had developed 'pop up' interactive health stalls in the school environment. Whilst working with young people in schools to achieve the Department Of Health's 'You're Welcome' criteria (2011), which aimed to make services as young people as friendly as possible. It became clear from feedback provided that young people wanted the school nurses to be more visible and to present health and lifestyle issues in a more engaging way than simply holding discussions in the classroom. Staff developed vibrant and exciting displays in the school corridors, hall, dining room or playground.
- The sexual health service offered clinics in various locations in the city. They offered evening and Saturday clinics to fit in with the needs of young people accessing the service.
- All environments where children and young people were seen were age appropriate.
- The sexual health service held drop in sessions at a school in partnership with the school nurses.
- The sexual health service offered an express service for those service users with no symptoms so that they could have their tests done by a health care assistant and cut down their waiting time.
- The therapy services obtained feedback from clients after group sessions to help them plan sessions that met their needs better. Feedback from some parents had been that venues were not child friendly so different venues were looked at.
- The CANI service was developed to facilitate early discharge from hospital.

Equality and diversity

- The trust had an up to date interpreter and translation policy.
- Staff told us they had access to interpreters through 'the Bigword' interpreting service. This was available as a face to face contact or over the telephone. The interpreting service could also be used to book British Sign Language interpreters if needed.
- Figures provided by the trust showed that staff had equality and diversity training. The trust had a target of 95% which most groups in the community children's services had reached. Only school health, nursing and midwifery registered staff, at 80% and health visiting, nursing and midwifery staff, at 88%, fell below the target.
- The sexual health service and the school nursing service attended Newcastle PRIDE to offer sexual health promotion information and screening to lesbian, gay, bisexual and transgendered (LGBT) people.
- The children's community nurses used Makaton for those children with communication difficulties. Makaton is a method of communication using signs and symbols.
- Practitioners told us they would text service users who were hearing impaired rather than ring them.

Good

Are services responsive to people's needs?

- School nurses had posters translated in to Romanian and Czechoslovakian for their sexual health drop ins.

Meeting the needs of people in vulnerable circumstances

- The sexual health service had employed a learning disabilities nurse who was able to work with young people with learning disabilities to encourage them to access the services.
- We saw a poster created by school health staff to signpost young people to sexual health and counselling services. The poster had been developed in different languages. Colour coded maps were used to signpost those young people with a visual impairment.
- The Family Nurse Partnership offered support to vulnerable, young first time mothers.
- The looked after children's team offered extra support to those children who were looked after. They held health promotion discussions with young people and followed up specific health issues. A nurse specialist post had been developed to cover those children and young people who had been placed out of the area.
- The sexual health service had an outreach team who could reach more vulnerable people.
- The sexual health team developed their child sexual exploitation (CSE) proforma to take account of children under 18 rather than under 16 which was the national proforma. An audit of this found that some 16 and 17 year olds experiencing exploitation would have been missed if they had not changed the proforma to cover those under 18.
- The 0-19 team worked closely with and could refer families to the Community Family Hub which included children's centres and intensive family support. This service had recently changed its referral criteria and only accepted referrals for families in the 30% most deprived areas of the city.
- Health visiting teams worked with asylum seeking families, supporting them to work with other agencies and help them access services such as food banks.

Access to the right care at the right time

- Patients referred to paediatric therapy services are seen within 18 weeks. The average waiting times in September 2015 were seven weeks for physical therapies and nine weeks for speech and language.
- Therapy services had a monthly meeting to discuss referrals and waiting times. Extra clinics were provided if needed and bank staff used to accommodate fluctuations.
- The community paediatric service had reduced their referral to initial assessment time for children with autism down to three months but acknowledged that there were delays following on from initial assessment.
- The head of community paediatrics told us that the community paediatric service wait times for GP referrals were within the non-admitted 18 week waiting time target. The average wait time for referral to new appointment, for referrals received in 2015, was 57 days.
- The health visiting service were meeting targets for birth visits done within 14 days.
- The looked after children team offered appointments to suit the young persons and carers needs including after school times and Saturdays.
- The looked after children's team completed 93% of initial health assessments within 28 days. They told us they were never non-compliant due to team factors but due to problems accessing families. Referrals were monitored and extra clinics arranged if needed to complete reviews within the allotted time.
- 71 % of review health assessments for looked after children were completed within the required time frame.
- Community paediatrics had a Did Not Attend (DNA) rate of 20-30%. Text message reminders were sent to patients.

Learning from complaints and concerns

- Half of the parents we spoke to were asked if they knew how to make a complaint. They said they were unsure but would be confident to raise any issues with staff.
- 0-19 service leaflets that were given out to parents had the process for making a complaint on the back.
- We observed posters in clinic areas informing people how to make a complaint.
- Staff we spoke to said that they would give parents a Patient Advice and Liaison Service (PALS) leaflet if they had a complaint.
- A monthly complaints panel email and take two minutes newsletter were sent to staff to disseminate learning from complaints.
- Staff told us they did not get formal complaints. Information received from the trust showed that there had been two recent complaints. One related to a child

protection report and one to a discrepancy between the community nurse and GP. As these complaints were dated December 2015 and January 2016 it is possible that any learning had not yet been disseminated to staff.

- Services were able to tell us about informal complaints they had received. For example, the sexual health service had received a complaint that there was no consistency with who they could take in to the consultation with them. This led to the service looking at this and the issue of consent.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well-led as good because:

- There were governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded upwards to senior management and downwards to staff.
- Staff were aware of the trust vision and values and their own services strategy.Leaders were supportive and encouraged staff engagement. Staff and public feedback was used to shape services and drive improvements.
- Staff felt valued and proud to work for the trust. Staff were given opportunities to share their views and provide suggestions.
- Feedback from children, young people and families was used to develop and influence the service.

Service vision and strategy

- As part of a cost improvement programme there had been the development of a new directorate structure in 2013. The community directorate were planning a two year celebration event which the executive team were going to attend.
- The community directorate strategy was focused on adult services. It was acknowledged that children's services were not addressed within the strategy. The directorate manager told us that the vision for the children's services would be dependent on commissioning arrangements. There was a citywide children's agenda.
- The children's community nursing team, community paediatrics and the looked after team were within the children's directorate. The children's directorate had a strategy, which had a clear vision.
- The 0-19 service had a strategy and vision that was in line with the overall trust strategy. Staff were actively engaged in the development of the strategy and the views of children and their families were incorporated.
- Staff we spoke to were aware of the vision and strategy and their role in achieving it, along with the overall trust strategy and vision. They told us about the core values of the trust.
- Staff told us that their appraisals were focused on the trust's Professional and Leadership behaviours.
- The sexual health service had an action plan in place to decrease the number of Sexually Transmitted Infections (STI's), increase access to services and decrease the rates of late HIV diagnosis, in line with the national agenda.

Governance, risk management and quality measurement

- The community directorate had a clinical governance lead.
- The trust clinical policy group and clinical risk group had quality and safety as a priority. The lead for the directorate would attend these meetings and then information was fedback through the directorate clinical governance meetings. Information was also fed up to the trust board from the clinical governance meetings through the clinical policy and clinical risk group.
- Within the community directorate, clinical governance meetings were held monthly. Minutes were seen from these meetings. Standing items discussed included incidents, complaints, audit, training and staff management, and the risk register.
- Minutes from these meetings were kept on a shared drive on the intranet for all staff to access. Information was also cascaded down through team meetings.
- Staff told us they were kept up to date with issues through emails.
- Team meeting minutes were seen from the different services.
- Professional development forums were held every four to six weeks for staff to share and discuss ideas.
- The community directorate manager held staff surgeries twice a month for staff to talk to her. Any concerns raised by staff could then be cascaded upwards to the senior management team.
- The head of therapy services attended team meetings to feedback information and for staff to talk to her about concerns.

Good

Are services well-led?

- The clinical audit forum had representation from all services within the community directorate. Services planned and prioritised their audit programme for the year ahead.
- Board meeting minutes were reviewed. Community services for children, young people and families did not appear to be regularly discussed.
- The community directorate had a risk register with identified risks and action taken to reduce the risks. The top risks were identified as security, IT and adverse weather.
- The service used performance dashboards to monitor quality and performance.
- The service had clear lines of accountability for safeguarding children and children who are looked after, with support provided by the safeguarding children team and looked after children team. There was a designated doctor for safeguarding and a designated doctor for child death.

Leadership of this service

- The service encouraged leadership development by offering acting up opportunities and the trust had a leadership programme in place.
- Staff told us they felt well supported by their managers and that they had an open door policy so that they could access them at any time.
- Staff felt connected to other teams in the service and felt part of the organisation.
- The clinical director provided links to the executive team which then fed in to the Trust Board.

Culture within this service

- The culture was focused on the needs of people who use the services. All staff we spoke with were focused on improving child health outcomes.
- Staff were encouraged to try innovative ideas to support people using the services.
- All staff we spoke with were proud to work for the trust and felt valued.
- There was an emphasis on promoting the safety of staff by the use of a lone working policy and staff were encouraged to follow the guidance.

Public engagement

- The service had a child friendly feedback form for the children and young people to tell them whether they thought it was a good service or not.
- Family Nurse Partnership (FNP) clients gave feedback to the FNP advisory board.
- FNP clients were involved in the recruitment process for new staff. They had their own interview panel and devised their own questions.
- Services gained feedback from using 'take two minutes' cards. Feedback from people who used the services was used to make improvements, such as health visitors changing baby clinics to an appointment system.
- The sexual health service had a young people's forum that was able to influence the service. Young people had been involved with the design of banners advertising the service and they designed the style of the C card. The C card scheme offers free condoms and sexual health information to all young people under 25.
- Services displayed 'you said, we did' information which showed the feedback they had received from service users and what they had done in response. During our inspection the sexual health service was in the process of purchasing electronic message stands to advertise waiting times after feedback from service users.

Staff engagement

- Staff in the therapy services produced a 'therapy matters' newsletter which they filled with information such as new clinics on offer and outcome data. This was shared with other teams.
- Staff in the sexual health team had set up a service improvement working group. Some of the team had suggested changing working hours which would benefit the staff and the service. The new system was trialled and the new hours implemented.
- Staff we spoke with told us they were encouraged to share their views and put ideas forward.

Innovation, improvement and sustainability

- A cost improvement programme was in place and there had been cuts to budgets. This was managed well with new directorate structures created and different skill mixes used so that it did not impact on the quality of services provided.
- Therapy services held an annual event for celebration of good innovation.
- The school nurses won a Cavell Nurses' Trust Award for School Nursing Innovation and a trust award for their pop up interactive health stalls.
- The health visitors and school nurses won a trust award for their Hello/Goodbye sessions.