Solutions 4 Health Limited

Solutions 4 Health - Barnet

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We did not re-rate the overall service following this inspection. It remained requires improvement overall. At our inspection in November 2022, we rated the domain of safe as inadequate. We rated effective, responsive and well-led as requires improvement. Caring was rated as good.

This was a focused inspection that covered specific aspects of safe and well-led only.

- The service had made progress in addressing most of the concerns identified in the last warning notice issued in November 2022, but further work was needed to fully address the breach of regulation and to ensure that improvements were embedded and sustained. We found on-going concerns with the management and oversight of children and families transferring in and out of the service. This meant that children and families who were potentially vulnerable or high risk might not be identified or supported in a timely manner.

We identified that:

- Not all children and family safeguarding concerns were managed appropriately when children transferred in and out of the service.
- The service leaders had failed to ensure that the assurance systems in place were robust enough to monitor, identify and address risks that impacted on patient safety.

However:

- Staff had undertaken level three safeguarding training for adults and children and were receiving regular safeguarding supervision.
- The service now had a specific policy in place that guided staff on how to respond to bruising injuries in non-independent mobile babies.
- Staff confirmed that the culture within the service had improved, they were well supported and could raise any concerns without fear of victimisation.

As a result of the concerns we identified, we issued the provider with two warning notices under Section 29 of the Health and Social Care Act 2008. The provider had failed to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We require the provider to make the necessary improvements and be compliant with the regulation by 30 June 2023. You can see full details of the regulations not being met at the end of this report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for children, young people and families	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Solutions 4 Health - Barnet

We undertook this unannounced, focused inspection of Solutions 4 Health Barnet to follow up on the actions taken by the service to address the breach of regulation as a result of the section 29 warning notice served following our comprehensive inspection in November 2022.

At the November 2022 inspection, we found that systems and process for safeguarding were not robust. We found that families and children moving in and out of the service were not managed in line with the service's own policy, health visitors and allocated health professionals were not receiving safeguarding supervision, low compliance rates for safeguarding level three training and the service not having an appropriate escalation pathway relating to the management of bruising in non-independent mobile babies. The warning notice required the provider to make improvements by 13 January 2023.

The Solutions 4 Health - Barnet service provides an integrated health visiting and school nursing service that supports children and young people aged 0 to 19 and their families.

The service covers the London Borough of Barnet. The health visiting team is comprised of three locality teams: South, East Central and West. The school nursing team are not split into localities.

The registered provider of the service is Solutions 4 Health. The delivery model for the health visiting team is based on the nationally mandated Healthy Child Programme (HCP). The health visiting team delivers the part of the HCP that is for children aged 0 to 5. The programme requires children and families to receive five mandatory checks: an antenatal contact at 28-weeks pregnancy, a new birth visits within 14 days of birth, 6 to 8 week reviews, 1 year development reviews, and 2 to two-and-a-half-year development reviews.

The school nursing team delivers the part of the HCP that is for children and young people aged 5 to 19. The Healthy Weight Nursing team are part of the wider school nursing team and deliver the mandated National Childhood Measurement Programme. The service also has an oral health team and an infant feeding support team. The service supports children and families in their homes, children's centres, clinics, health centres, GP premises and schools.

The regulated activities attached to this service are diagnostic and screening procedures, family planning and treatment of disease, disorder or injury.

There is a registered manager in post.

At the inspection in November 2022, we rated the service as requires improvement overall. Safe was rated as inadequate, effective, responsive and well-led as requires improvement, caring was rated as good.

Outstanding practice

We did not identify areas of outstanding practice.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Action the service MUST take to improve:

- The provider must ensure that robust safeguarding systems and processes are in place to ensure children, young people and their families were appropriately assessed, reviewed and identified risks are managed in a timely manner. Regulation 13 (1)(2)(3)
- The provider must ensure that it has robust governance and assurance systems in place to oversee and monitor the quality and safety of care. Regulation 17 (1)(2)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Community health services fo children, young people and families

Inspected but not rated

Safe	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

We did not inspect the whole of the key question during this inspection. We found no evidence to suggest the existing rating of inadequate should be reviewed or changed.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all children and family safeguarding concerns were managed appropriately when children transferred in and out of the service.

At our inspection in November 2022, children and families did not receive the right level of care and support when they transferred in or out of the service. During the inspection, the service continued to face substantial challenges in ensuring that children and their families received the right level of care and support when they transferred in or out of the service. There were waiting lists for allocation in each locality team. For example, in the East Central locality team there were 213 families with children over the age of 1 currently on the waiting list for allocation who had transferred into the borough. In the South locality team there were 109 families waiting allocation with children over the age of 1 who had transferred into the borough.

During our inspection we reviewed 21 patient records for families and children that had transferred in or moved out of the service. We found that in 19 of the 21 records, the children and their families did not receive the right level of care and support when they transferred in or out of the service to ensure they were protected from improper abuse and treatment.

Families were not allocated and seen in accordance with the provider's own policy. Children and families not being allocated, and risk assessed in a timely way impacted the level of care and support they received. The lack of adherence to the provider's own policy increased the risk of children and their families being put at risk of avoidable harm. For example, a child had been referred into the service on 5 September 2022. On the 12 January 2023 the patient record detailed that the child had still not been allocated a health visitor. An alert indicating the child's vulnerability had not been put on to the electronic record system. Another family had transferred into the service on 2 November 2022. The records detailed that there had been attendance at the emergency department. Whilst On 13 January 2023 the duty health visitor had identified this record of not being seen. At the time of inspection, no health visitor had been allocated.

A family transferred into the service from on 17 January 2023. On the 19 January 2023 the patient moved out to another borough. The patient record did not detail if the child had been followed up.

Community health services fo children, young people and families

Inspected but not rated

In November 2022 we found that not all staff had completed safeguarding adults and children level three training. At this inspection we found improvements. Training compliance for level three safeguarding training was at 95%. Staff we spoke with confirmed they had undertaken this training. Staff within the safeguarding team and locality leads were undertaking level 4 safeguarding training.

In November 2022 we found that safeguarding supervision was not consistently taking place with the allocated health visitor or health professional. At this inspection we found improvements. Health visitors and allocated health professionals were receiving regular safeguarding supervision. Records showed that 99% of staff had received safeguarding supervision. We reviewed 5 care records and found that 4 out of the 5 records detailed that safeguarding supervision had taken place. This meant that health visitors were enabled to discuss, evaluate and reflect on the care planned for individual families with a trained supervisor.

Staff we spoke with confirmed they were receiving safeguarding supervision. Staff had access to safeguarding advisors who were available during core working hours to respond to frontline colleagues needing advice and support.

Since November 2022 the service had reviewed all level 4 children and families. These are families who require a high level of specialist support where children and families are at high risk. Work was in progress to review all level 3 families who required targeted support. The provider confirmed that all children under the age of 1 year and all targeted children over the age of 1 had been allocated a health visitor.

Changes had been made to the standard operating procedure for safeguarding supervision and the named nurse for safeguarding monitored the numbers of Looked After Children (LAC) Children in Need (CIN) and Child Protection (CP) per health visitor. Specialist health visitors with a vulnerable caseload received supervision fortnightly. Nursery nurses, the breastfeeding and healthy weight teams received group safeguarding supervision every 8 weeks.

The provider had added a new supervision template to the patient record for all safeguarding supervision and safeguarding concerns to be recorded. This enabled better oversight and monitoring of safeguarding concerns.

At our inspection in November 2022, we found that the provider's 'safeguarding children's policy did not include any reference to the management of bruising in non-independent mobile babies. There was no escalation pathway in place. At this inspection, we found that the bruising in non-independent mobile babies has been added to the safeguarding policy as an addendum. Clinical staff confirmed they were aware of the addendum, had been provided with leaflets relating to bruising in children and could refer to a flow chart which detailed the escalation process to follow. They also reported they attended the providers safeguarding symposium in January 2023 which included the update relating to the bruising in children.

Is the service well-led?

Inspected but not rated

We did not inspect the whole of the key question during this inspection. We found no evidence to suggest the existing rating of requires improvement should be reviewed or changed.

Leadership

Community health services fo children, young people and families

Inspected but not rated

Leaders had the skills and abilities to run the service. The service mostly recognised that parts of the service that needed to improve and had employed external consultants to support the service with the changes. An external safeguarding consultant had been employed to support the service with managing safeguarding.

Staff told us that there had been many improvements to the service since the provider took over in April 2022. They reported increased morale, involvement and consultation in the service development, improved training, additional staff and a culture where staff were able to speak up without fear of victimisation.

Governance

Whilst leaders had governance processes in place, these did not always operate effectively. The service leaders had failed to ensure that the assurance systems in place were robust enough to monitor, identify and address risks that impacted on patient safety.

Whilst leaders had governance processes in place, we found that the governance arrangements in place did not provide robust oversight to monitor, provide assurance and improve the quality and safety of care to children and families using the service.

At our inspection in November 2022, we identified a regulatory breach because governance processes did not always operate effectively. At this inspection we found that children and families were still not being assigned a health visitor in an appropriate time scale and in line with provider policy. The service had not developed a robust oversight system for the transfer in and transfer out of families and children in the borough.

The action plan submitted by the provider following the serving of a warning notice in November 2022, detailed that an audit of transfer in and out movements would be completed by 31 March 2023. This audit had not taken place. The provider had not informed the commission that there was a delay in achieving compliance in this area.

Information Management

The service collected reliable data and analysed it. However, the leaders within the service did not have direct access to the electronic record system.

Leaders within the service did not have direct access to the electronic records system. Leaders were waiting for individual smart cards. Information could be reviewed once it had been pulled from the system from staff who did have access. This meant that leaders within the service did not have access to information in a timely manner.

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust governance and assurance systems in place to oversee and monitor the quality and safety of care. Regulation 17 (1)(2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that robust safeguarding systems and processes are in place to ensure children, young people and their families were appropriately assessed, reviewed and identified risks are managed in a timely manner. Regulation 13 (1)(2)(3)