

Solent NHS Trust

R1C

Community health services for children, young people and families

Quality Report

Solent NHS Trust
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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)
R1C17	St Mary's Hospital		SO19 8BR
R1CD1	Adelaide Health Centre		SO16 4XE

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Requires improvement

Overall, this core service was rated as 'requires improvement'. We found that community health services for children, young people and their families were inadequate in the area for safe. Requires improvement for effective, responsive and well led, and caring was rated as good.

We rated the service as requires improvement because:

- Medicines were not always managed safely or consistently. This was noted in the special schools, and this posed risks to the health and safety of children and young people. Staff practices and processes in schools did not follow regulatory guidelines for the safe management of medicines. This included medicines which were not stored, dispensed and administered safely. There were limited updates and competency assessments undertaken in the schools to ensure this was delivered effectively and safely where non clinical staff undertook clinical duties.
- A piece of emergency equipment was not available in one school which could impact on the immediate safety of children with profound disability. Maintenance of equipment was not entirely robust as some essential equipment had not been serviced in line with the trust's policy.
- Staffing levels and skill mix were planned, and reviewed to meet the level of need. However, staff vacancies meant there were sometimes insufficient staff such as health visitors, school nurses and therapists to deliver care in a consistent manner and to meet the needs of children and their families
- New births visits and development checks were not always completed within the recommended timescale and this impacted on the delivery of the Healthy Child Programme. This was due to unfilled health visitors' posts. The school nursing service and therapy service had reduced capacity, due to staff shortage in order to deliver public health improvement programmes, and some clinics and education sessions had been cancelled.

- Staff reported incidents about safety although this was not entirely consistent. Incidents were investigated and, following root cause analysis, practices were reviewed and lessons learned shared.
- Care and treatment took account of best practice and evidence based guidelines when delivering care across the services.
- All staff including bank staff were provided with induction and training, to support them in their role. Clinical staff were supported with revalidation.
- Feedback from children and their families was complimentary and highly positive about the care and treatment they received. Care was provided in a respectful and compassionate manner at all times. People were treated with dignity and respect by staff and relationships were viewed positively.
- Parents and children were involved in their care and treatment, and consent obtained appropriately with age and ability to consent taken into account prior to providing care.
- The referral to treatment time of 18 weeks was not consistently achieved in the Hampshire therapy service due to unfilled posts which impacted on care delivery.
- The issues with IT connectivity meant that staff could not always update patients' records in a timely way.
- Alerts were not put onto the system routinely to immediately advise practitioners and managers to the presence of children in a case and this clearly elevated risk that child welfare may not be prioritised.
- There had been many recent changes in the staff's structure and there was a mixed view of the visibility of senior managers and the executive team. Staff felt the level of changes which had resulted in the loss of experienced staff had not been well communicated and managed.
- The governance process was not sufficiently robust in order for action to be taken and mitigate the risks. The quality assessment system was not always able to appropriately measure outcomes due to unassessed risk and the management process had not identified an area of substantial risk which we raised with the trust.
- Action taken following the staff's survey included the increased visibility of senior management staff.

Summary of findings

Although staff felt they received support from their immediate managers, they viewed management overall as top down with too many changes occurring at the same time. These included new IT system, locality and team changes and inadequate access and support

- The public health nurses in Southampton were working collaboratively with the No Limits service to deliver integrated health and emotional wellbeing to children in school.
- Staff set up links with health and support groups in their local areas, for example to meet the needs of minority groups. Systems were in place to identify those who may be vulnerable and to provide targeted care. The needs of different people, in different localities, were taken into account when planning services.

- There was a service strategy for paediatric, health visiting and therapy services which included development of carers' surveys and improving nutritional and breast feeding initiatives.
- There was a low level of complaints across children services, complaints were investigated and cascaded at staff's meetings for shared learning.
- There were some examples of outstanding care such as the COAST team supporting children at home. The interactive "Trachey bus" which supported children with a tracheostomy (an artificial opening in the windpipe enabling to assist with breathing) to attend school.

Summary of findings

Background to the service

Solent Health NHS Trust provides a range of community based services to children and young people in the Southampton, Portsmouth and Hampshire areas. Care is provided in a variety of settings including schools, health clinics, mobile Trachey bus and home visits. Services provided include health visiting, school nursing, community paediatric nursing, community paediatricians, occupational therapy, physiotherapy, learning disability nursing, podiatry, education health, orthotics, care support assistants and speech and language therapy.

Solent NHS Trust provides services to meet the physical, mental and psychological needs of children and young people aged 0-19 years. The inspection included three specialist schools: Mary Rose, Rosewood and Cedar which cater predominantly for pupils with severe and complex needs such as learning difficulties, physical disabilities, medical conditions and autistic spectrum disorder.

There is a well-established children's outreach assessment and support team (COAST) service in Southampton and Portsmouth. The outreach team provides care and support to children and their family in their own home with the aim of preventing hospital admission.

The interactive "Trachey bus" is an innovative service which was available to children living in Portsmouth. This

provided valuable care to children with an established tracheostomy (an artificial opening into the windpipe (trachea) that is held open by a tube. This helps the child to breathe more easily.)

The percentage of young people who were not in education, employment, or training (NEET) showed Portsmouth scored higher and was above both the South East and National averages. Portsmouth scored 7%, and had the second highest proportion of 16-18 year olds who were NEET and, at 18 %, the 3rd highest proportion of 16-18 year olds whose activity was unknown.

Child Health Profiles for Portsmouth and Southampton show the level of child poverty and the rate of family homelessness are worse than the England average. In Southampton and Portsmouth, 22% of children under the age of 16 are living in poverty, 8.5% in East Hampshire, and 11% in Hampshire.

The infant mortality rate is better than, and the child mortality rate is similar to, the England average. In Southampton and Portsmouth 20-21% of year six children are classified as obese compared with 12% in East Hampshire. In Portsmouth 19% of school children are from a minority ethnic group and 30% in Southampton.

In Portsmouth and Southampton 95% of children had received their first dose of immunisation by the age of two which was higher than England average. By the age of five, 90 % of children had received their second dose of MMR immunisation.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspection: Joyce Frederick, Care Quality Commission.

The children and young people team consisted of 11 staff including 3 CQC inspectors, CQC pharmacist specialist, physiotherapist, occupational therapist, speech and language therapist, health visitors, a paediatrician and a paediatric community health manager.

Summary of findings

Why we carried out this inspection

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

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?

We carried out our announced inspection on 27 to 30 June and an unannounced visit on 8 July 2016. As part of the inspection we spoke with approximately 54 staff of all grades that included community care nurses, service leads, paediatricians, therapists (occupational therapists, physiotherapists and speech and language therapists), specialist paediatric nurses, health visitors, school nurses, children safeguarding leads, and administrative and reception staff.

We also visited these services across the localities in Portsmouth, Southampton and Hampshire.

- Cosham Health Centre.
- Battenburg Avenue CDC
- Somerstown Child Health Clinic.
- Northern Parade Children Health Centre.
- Portsmouth CDC
- Interactive Trachey bus

- Willows Centre Portsmouth
- Mary Rose School Portsmouth
- Cedar School
- Rosewood School
- Newtown Road
- North Parade Infant School
- St Monica School
- Fort Southwick Southampton
- Better Care Centre Southampton
- Weston Sure Start
- Early years language project Weston Shore
- Highbury Infant Centre
- Oak Park community Centre

We reviewed approximately 56 care records for children including those from health visitors, therapists, school nursing, and community nursing. We also spoke with 12 families and observed how children were cared for. We received feedback from parents and carers who we contacted by phone, and from feedback boxes in clinical areas at the trust.

Prior to the inspection, we also held focus groups for staff working at the trust and they were able to tell us what they were proud of and also the areas which needed to improve. We reviewed other documentation from stakeholders and performance information which we hold from the trust.

What people who use the provider say

People told us they were given a good level of information and were involved in their care. Parents told us staff put their children at the centre of their care and they said they received more information about how to "cope" with their child's illness. The Trachey bus was seen as an invaluable service for children attending schools which people felt "could not ask for anything better" than the service provided.

People were offered choices of clinics and efforts were made to fit appointments after school and took into account parents' work. New mothers were positive about support they had received with breastfeeding and breastfeeding clinic.

Summary of findings

Parents were complimentary about the therapists support and plans they had developed to manage complex care needs and empowered them to support their children.

Comments from parents included “I could not have done this without the nurses” in relation to the support they received and caring for a child with cancer. Other comments included: “Amazing care and support”.

The nurses explained “everything and made it easy” and a parent said “they think about the child and also the family”. They felt there was continuity in the community nursing team and commented “we see the same nurses and we like this “ and another person said ; “they all work well as a team.”

Good practice

- The children’s outreach assessment and support team (COAST) has continued to develop; providing a service which has positive impact on the care children received in their homes, and in reducing hospital admission.
- The interactive Trachey bus is an innovative service that has huge impact on the lives of children living in the Portsmouth area. Currently the Trachey bus can safely accommodate four children and facilitate these children attending school.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the trust **MUST** take to improve

The trust must ensure:

- Urgent equipment such as suction machine must be available in schools in order to meet the needs of children and young people.
- Medicines are administered safely in special school and must include a valid prescription and protocol for as required medicines in special schools.
- Medicines in special schools are administered from the original labelled container ensuring medicines are given to the correct patient, correct dose, appropriate information and advice.
- Medicines are stored safely and securely in all schools and in line with current legislations, trust’s policies and standard operating procedures.
- Staffing is reviewed and there are adequate staff to deliver the healthy child programme, health visiting and school nursing services.

- Robust processes are developed for identifying risk and monitoring quality across all services particularly school nursing.
- Staff receive training and appropriate supervision of their practices and their competencies are assessed when they are undertaking extended roles

Action the trust **SHOULD** take to improve

The trust should ensure:

- Equipment is checked in line with trust policy and there is a process to track this to provide assurance they are fit for purpose.
- Children’s views about the service are sought, and include age related surveys to inform service provision.
- IT Systems are further developed so that records are available as needed.
- Access to wheelchair services is reviewed in order to meet the needs of children in the community.
- The trust should consider how it continues to engage with staff to ensure that they are kept suitably informed in respect of the on-going transformation of services.

Solent NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Inadequate 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

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

We rated safe as inadequate because,

- Safety systems and standard operating procedures were not followed with regards to the safe management of medicines in the schools.
- Medicines were not always managed safely or consistently. This was noted in some special schools which posed risks to the health and safety of children and young people. Staff practice and processes in these schools did not follow regulatory guidelines for the safe administration of medicines. There was clear evidence of poor medicines administration practices including the drawing up of multiple medications in unlabelled syringes. There was no protocol in one school for staff to follow when administering emergency medicines. This may pose risk of children receiving emergency medicines inconsistently and is not in line with good practice guidelines.
- A piece of emergency equipment was not available in one school which could impact on the immediate safety of children with profound disability.
- Some equipment in schools was not checked and tested to ensure they remained fit for purpose posing safety risks.
- There were high levels of vacancies in health visiting and school nursing teams which impacted on care delivery and ability of some staff to attend safeguarding conferences. Vacancies and the use of an outdated assessment tool resulted in higher than recommended health visitor caseloads in deprived areas.

Are services safe?

- Patients' records were not always recorded and updated in a timely way due to IT connectivity issue and pressure on staff's time. This posed risks of delays in recording and incomplete records.
- Staff reported incidents and there was evidence of lessons learnt. However this was not consistent across all services. Some staff said they had not reported incidents due to staffing shortages and high workload, other staff did not recognise concerns such as safety issues in medicines' administration.
- Compliance with safeguarding training was below trust target in some teams and it was not clear that relevant staff had completed level 3 training as needed when working with children.

However,

- In the clinics, medicines such as vaccines were stored safely and in line with guideline to maintain the cold chain.
- There was an effective process for safeguarding children which included safeguarding supervisions for staff.
- Staff adhered to infection control procedures to minimise of the risk and spread of infection.
- Records were stored safely and securely, although access to records was variable due to IT issues. Records were in electronic and paper forms which meant staff had to input some of these manually to capture all information about safety and care of children.
- The duty of candour process was applied as required which included evidence of action taken information being shared with the relevant people.

Safety performance

- In the period January 2015-February 2016, there were six (6) serious incidents in children and young people's services which staff reported to the trust's incident reporting system requiring investigation. These were discussed and cascaded to staff for lessons learned.
- From July 2015-2016 there were 123 reported incidents across the services for children and young people. The majority, 110 of incidents were categorised as "no harm". There were 13 moderate and the trust had rated three of these as high as related to unexpected deaths. There was evidence that incidents had been investigated and remedial actions taken.

Incident reporting, learning and improvement

- The knowledge about incidents reporting amongst the school nurses' team was not consistent. In one team at Portsmouth, staff told us they had only recently started reporting incidents since June 2016 and this was due to workload issues. Another team knew how to report incidents but did not recognise some issues as being incidents which they needed to report which may impact on safety of children. Other staff used the trust's electronic system and knew how to use the system.
- Staff could not always access the online incident reporting system due to technical issues with the computer systems. This meant that incidents were not always reported in a timely manner.
- Some staff told us they did not get feedback or updates following an individual incident. However learning from incidents was shared through team meetings, the staff's newsletter 'Your Solent' and supervision. For example, following an incident where a child had suffered a fracture, we found a thorough root cause analysis was completed and action plan developed which included training for staff. Learning from the incident was shared across all the school teams. The trust also sent out newsletters to staff.
- Safety alerts were communicated to locality leads and these would be cascaded to staff. However not all staff could recall receiving safety alerts which may impact on their roles.
- Health visitors' team told us workshops had been facilitated to share learning from serious case reviews. This had included learning around the importance of identifying and following up those children who did not attend health appointments. Another example following a serious case review had identified the need to 'think family', to be child focussed and the importance of level 3 multi-agency safeguarding training. An action plan was developed to address the shortfalls identified.
- Learning from incidents was not always appropriate in addressing the initial problem. For example, a healthcare assistant administered the incorrect feed to a child; however, the learning from the incident focused on the process of labelling rather than the prescribing of feeds, training and competency of staff.

Duty of Candour

- The Duty of Candour is a regulatory duty that relates to openness and transparency legislation and requires

Are services safe?

providers of health and social care services to notify patients or other “relevant persons” within a reasonable time. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.

- Staff were aware of their responsibilities to be open and transparent although none of the staff we spoke with were able to give an example where the duty of candour had been initiated. The trust, however, did provide evidence that the duty of candour was being applied. For example, there had been an information governance breach where they applied the duty of candour.
- Therapy staff had followed this process and we found good evidence of open and transparent communication with the parent of a child and action the trust took to ensure lesson learned.

Safeguarding

- Health visiting, community nursing teams and therapists were able to recognise safeguarding concerns for children and young people and showed a good knowledge and awareness of the safeguarding processes and their responsibilities in protecting children from harm. All staff we spoke with told us they were able to access safeguarding advice when required and knew how to report any safeguarding concerns.
- The training data for safeguarding children showed that overall 83% of staff had completed this training. The level of compliance was variable across services. Paediatric medical Portsmouth achieved 67%, North Hampshire locality was the lowest at 49%, other North Hampshire locality achieved 86 -90%. FNP Portsmouth 100% and FNP Southampton was 83%. Overall, the trust’s target of 85% did not appear to be met. However, the trust has since provided us with documentation reflecting much improved performance on this figure which was taken from February 2016.
- Level 3 safeguarding training relates to the competencies and level of training for clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child. This would include designated staff including school nurses and paediatricians. These staff were not aware of the level of training they had received, and data from the trust did not reflect what percentage of staff had received safeguarding training at level 3.
- The trust’s safeguarding children policy dated June 2016 included the revised Working Together 2013 government guidance, and gave clear guidance on what action to take. Guidance in the policy set out that if staff had safeguarding concerns about a child there was a process of identifying the concerns, and assessing the risks. If a protective plan was needed then other support could be provided for children before a referral to Children’s Social Care was actioned. Staff told us that there was limited support available in this way. Staff reported that some caseloads had high levels of need, responding to this need and safeguarding work was a large proportion of their work.
- Shortages in staff numbers and high caseloads in some areas had impacted on number of staff’s ability to attend local safeguarding conferences. This staff told us may impact on their practice as they did not have the up to date information.
- The National Health visiting service specification 2014/2015 states that Health visitors (HVs) must receive a minimum of 3 monthly safeguarding supervisions of their work with their most vulnerable babies and children. These could include children on a child protection plan, those who are ‘looked after’ at home and those for whom the health visitor had a high level of concern. Supervisions for health visitors occurred regularly as group meetings and staff said they felt supported. They also found these useful opportunities for learning from different teams.
- There was a clinical and safeguarding supervision policy dated April 2014 which set out the frequency, components and tools to help in the supervision process. Group supervision by specially trained supervisor occurred every three months. Staff could access one to one advice with the safeguarding lead if needed on a case which staff said was good.
- Health visitors were notified by the paediatric liaison health visitor of any emergency department attendances of a child four years of age and under where there were concerns raised regarding their safety.
- In Portsmouth a nurse specialist worked with doctors in providing support to children who may be victims of sexual abuse. This ensured the best interests of the child were protected.

Are services safe?

- There was a lack of awareness amongst some staff to observe signs of female genital mutilation (FGM). This meant opportunity in identifying FGM may be missed, including referrals to the appropriate agencies and police.
 - Data received from the trust following an audit carried out in October 2015. This looked at the percentage of children under five transferring in and out of the area who were subject to a child protection plan (CPP). It showed 91% compliance with documenting the date the health visiting team were informed of the child transferring in. For the transfer in visit carried out by the HV this was 82%. The trust had identified inconsistencies in the recording process for children under five who were subject to CPP. An action plan was developed which included safeguarding named nurse liaising with child health record department and flow chart for HV and admin staff to follow. .
 - The trust's annual children safeguarding report 2014-2015 indicated that they had redesigned safeguarding training at level 2 and 3 to comply with NICE guidance 2009 and other evidence such as child sexual exploitation, health and domestic violence, parents with learning difficulty and any learning from serious case reviews.
 - Within Solent NHS Trust, the director of human resources was responsible for dealing with all allegations made against staff working with children. Referrals were made as required to the local authority designated officer (LADO). The LADO had a statutory responsibility within the trust to manage and oversee safeguarding allegations against people who worked with children. For the period of 2014-2015, Solent made no referrals to the LADO team, although advice was sought on occasion.
- Medicines**
- Medicines were not kept securely and managed safely, effectively and in line with the trust's policy in three schools we visited. In Mary Rose School, the emergency drug cupboard was not maintained securely. This was in the staff's kitchen and insecure, as the keys were left in the door and non-clinical staff and others had access to this area. We raised this as a serious concern during our inspection. However when we returned for an unannounced inspection on 8 July 2016, we found no action had been taken to maintain this key safely. Other actions had started and the trust has since told us they were completed on the day of the unannounced inspection.
 - The emergency medicines' cupboard contained Buccal Midazolam used for the treatment of epileptic fits. The cupboard contained 40 lots of Buccal Midazolam for individual pupils which was unlocked and could be accessed by non-clinical staff and others.
 - Buccal Midazolam is classed as a schedule 3 drug and is governed by the Misuse of Drugs Act 1972 and the Misuse of Drugs Regulations 1985. School nursing staff confirmed there was no protocol for the administration of this emergency medicine at the school or on the trust's intranet. There was also no written information on how to administer this medicine. We observed staff administering this medicine to a child which was not prescribed on the "as required" section of the medicines' administration record held at the school. This meant staff were not adhering to the safe management of medicines and meeting prescription requirements including details of dose, form, strength and directions for administration. This posed serious risks to children and young people's health and safety.
 - At Mary Rose school another medicine's cupboard contained 23 plastic containers of prescribed medicines for children at the school. The cupboard was locked; however the key was left on the worktop and was not secure and posed risk of unauthorised staff and others having access to prescribed medicines. During the unannounced inspection we observed nine staff members accessing this area which included non-clinical staff.
 - Medicines were brought into the schools in their original containers as required. The Royal Pharmaceutical Society guidelines (RPS) handling medicines states that medicines must be given from the container they are supplied in. National Institute of Clinical Excellence (NICE) define medicines optimisation as 'a person-centred approach to safe and effective medicines use, enabling children and young people to obtain the best possible outcomes from their medicines.
 - At Mary Rose school we found there were medicines in syringes for 23 children. A registered nurse confirmed all children's medicines were drawn up into syringes at 8am each morning by them to be administered by staff which may include teaching assistant at lunchtime. This process of "secondary dispensing" posed serious risks of

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accidental mix-ups and errors and poor practice. A staff member told us they would not “have the time” to dispense medicines to individual pupil from the original container. Some children had three medicines drawn up and staff could not be certain which medicines were in the syringes. Registered nurses were not following regulations and recent guidance published by the Nursing and Midwifery Council (NMC), RPS and NICE on administration of medicines and this posed risks to the pupils.

- We observed medicines being prepared in syringes for children going out on a school trip. The medicines for the day were drawn up, labelled by the nurse, and then given to the teacher to administer the medicines. During the inspection we observed medicines in syringes which had been drawn up for three pupils were transported in the same plastic container which posed risks of these being mixed up.
- All healthcare providers holding controlled drug (CD) on the premises must have and comply with, an approved Standard Operating Procedure (SOP). School nurses confirmed they did not have a SOP and they were planning to develop this at the schools. Policies for the safe storage, handling and administration of medicines were not in place at one of the schools we visited.
- The process for discarding medicines safely was not robust. At Rosewood school; we found a clinical waste container that was used for disposal of expired/unused medicines. It was possible to access these medicines as this was unlocked. The staff told us they did not lock the clinical room door during school hours and therefore anyone at the school could access these medicines. At the unannounced inspection the school had taken action and locked the container.
- Staff at Mary Rose School supplied and administered “homely remedies”. These are off the counter medicines purchased without a prescription. Medicines which were administered to children included Ibuprofen and Paracetamol. One of the recommendations to reduce medicines errors and harm is to use the “five rights”: the right patient, the right drug, the right dose, the right route, and the right time (Institute of Health Improvement). The procedure for administering these medicines was not robust and there was no policy, procedure or detailed protocol to assist the staff in

choosing the medicines for the appropriate age range and dosage. There were risks that off the counter medicines may interact with children’s prescribed medicines and cause harm.

- School nursing staff did not consistently follow their procedure for checking and recording the room and fridge temperature. The efficacy of medicines could be affected if these were stored at the wrong temperature and not according to recommendation.
- There was no evidence of competency assessments on oral medicines administration for education staff although they were supporting children with their medicines.
- The trust completed a medicines’ audit trust wide and a medicines’ security action plan had been developed with set timescales for action to be completed in April to June 2016. There was no audit of medicines management in schools which meant poor practices were not identified and risks relating to medicines management were not identified and no actions could be taken to mitigate those risks.
- Staff followed guidelines ensuring safety of children receiving vaccines. School health nurses used patient group directives (PGD) when administering vaccines. A PGD provides a legal framework that allows registered nurses who had completed appropriate additional training and signed the PGD to supply and/ or administer a specified medicine to a pre-defined group of patients.
- The paediatric community nursing team nurses provided specialist advice on medicines used for asthma treatment and GPs were responsible and prescribed medicines to children as needed.
- We observed storage of vaccines in different locations such as community clinics. The safe storage and preservation of the ‘cold chain’ was consistently managed. The “cold chain” is a system of storing vaccines within a recommended temperature range to ensure they maintain their efficacy. Staff in the schools maintained a log and the fridge temperature were checked daily.

Environment and equipment

- We found that equipment in some schools was not always maintained safely. At Rosewood school, the

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emergency suction equipment was not available, as staff told us this was on loan to a parent. This meant this essential equipment was not available in an emergency situation and may put children at risk.

- At Mary Rose school we identified a number of equipment such as suction machine, overhead hoist, children weighing scales which were due to be safety tested and serviced in May 2016 and these were all overdue. We were not assured there was a robust system for checking equipment and ensuring these were serviced and fit for purpose. We raised this with the staff at the time of the inspection.
- At the clinics we visited, there were appropriate arrangements for the management of waste, including clinical waste and sharps.
- Staff and parents of children receiving services from the trust, raised concerns regarding the availability of equipment and in particular access to wheelchairs, with waiting times of up to a year or more. We were told this impacted on the safety of children who had outgrown their “buggies”.
- At the schools we visited, staff confirmed children were provided with and had appropriate equipment to meet their needs. These included wheelchairs and adapted frames to support and maintain children’s independence. We saw a variety of equipment was available to children at all the schools we visited and these were in good condition.
- Health visiting staff said they had enough equipment to deliver care. We observed seven sets of weighing scales and found they were all up to date and calibrated yearly. Child friendly environment for crawling babies soft cleanable mats were seen in clinics and breastfeeding group. There were also safety gates to kitchen areas. In breastfeeding groups, safety thermos mugs were used for hot drinks for mothers to minimise the risks of scalding from hot drinks.
- Staff were provided with mobile phones and laptops. Staff were able to access desk top computers or docking stations at their bases and told us there was enough office space. Many health visitors moved base within last 4-6 months and there appeared to be enough “hot desks” in the open plan offices. Staff said they could always access a hot desk if needed and there was also facility to use one of the quiet rooms for private conversation.

- Medical staff told us the arrangement of hot desking was not effective for them as they no longer had an office. This impacted on their ability to carry their work and included dictating letters which they said was problematic for them.

Quality of records

- The trust had implemented their electronic record system and there was mixed feedback about the functionality of the new record system. Some records were completed manually and were later put onto the system which may not be readily available.
- At Mary Rose School, we looked at seven records for children who were at risk when drinking thin or clear fluids and were prescribed thickened fluids. This involved a thickening agent added to their fluids to achieve varying consistency according to speech and language therapist (SLT) assessment to ensure they took their fluids safely. One child had a detailed care plan in place regarding the consistency of their food and fluids, risks such as aspiration and support they needed to achieve this safely. The other records had SLT assessments and no care plans had been developed to ensure children who were at risks received their food and fluids in a consistent and safe manner. Staff confirmed they did not have detailed care plans and a staff member told us “when you are told, you do tend to remember”.
- Records were maintained safely and securely with restricted access including electronic records which were password protected in line with data protection guidelines.
- Staff working across community children’s services said access to records was problematic due to issues with connectivity to the IT system and staff told us this was a ‘struggle’; however the trust was aware of this and they were working towards resolving this issue. We visited one clinic where staff could not upload information electronically and therefore had to complete paper records and add them to the system when they returned to their base which meant sometimes records were not contemporaneous.
- We reviewed 26 sets of records across the community children’s services; this included personal child health record books held by parents for their children and used by staff working with children. The books held by parents and carers contained appropriate information

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about the child, recording assessments, development checks, immunisations, and the child's progress with weights plotted on centile charts. They were accurate, complete, and legible and signed.

- Staff had paper diaries, these and any paper documentation was carried in a red locked wallet to keep records secure and maintain confidentiality.
- The looked after children (LAC) report highlighted issues with the current IT as it did not reflect key learning from national serious case reviews. This included the need to identify children in the household of clients of adult service users rather than only recording known children of the client. Even where it was known that there were children within a case, it found details and information about children hard to find. The trust is aware of this and an action plan is in place to address these issues

Cleanliness, infection control and hygiene

- We attended home visits with health visitors and nursing staff and observed clinics at schools. Staff adhered to 'Five moments for handwashing' as per World Health Organisation (WHO) guidelines including hand washing and gels. The staff followed the trust's bare below the elbow policy when providing care.
- Personal protective equipment such as gloves and aprons were available and used appropriately.
- In clinics we observed scales and other equipment being cleaned between clients, including toys in health venues. Staff cleaned and replaced the paper roll on the scales between babies as part of the infection control process.
- Rooms used for clinics and appointments had cleaning schedules which staff followed. However some clinical rooms had carpets which increased infection control risks and management of spillage.
- Patient led assessments of the care environment (PLACE) survey published in August 2015 showed the trust had achieved 96% which was similar to the national average of 97%.
- Infection control training was part of the trust's mandatory training programme. It was delivered as two modules; level one (three yearly) and level two (yearly). Across children and young people's services at the end of January 2016, 92% of staff had completed level one training, and 82% of staff had completed level two, which was close the trust's target. Senior staff told us

this was monitored and staff were sent reminders to ensure compliance with mandatory training. However staff told us some training was cancelled due to staff's shortage.

Mandatory training

- The trust's target was for 85% of staff to have completed mandatory training. The trust's mandatory training included quality governance, health and safety, moving and handling, basic life support, risk management and infection control. The trust confirmed that bank staff also completed this induction. For example, mandatory training overall staff had achieved 83%. Mandatory training included equality and diversity at 90%, fire safety was 82% and health and safety 79% and resuscitation was 92%.
- Staff told us it was difficult to book and attend multi-agency safeguarding training and face to face training due to a shortage of places and having to prioritise work commitments over training. Senior staff confirmed that work commitments did sometimes prevent staff from attending training.

Assessing and responding to patient risk

- The trust used the Healthy Child Programme to identify and support children, young people and families according to their level of need. The levels of service used depended on need and the risk of harm. The trust had arrangements in place to coordinate and support these children and their families and meeting their needs.
- There was more targeted support such as the universal service, the universal plus, for those requiring a brief period of extra support and the universal partnership plus, for families requiring intensive support involving other professionals. This involved referrals to other professionals such as speech and language therapy and continence service.
- Children's electronic records identified which level of service children were receiving and described their specific needs and risks. Alerts could be added to the system to indicate specific risks such as domestic abuse, which ensured staff, were aware of and had speedy access to individual needs and risks.
- Assessments were recorded in a timely way. We saw a range of records across children's services, for example, risk assessments were completed. The trust had policies and pathways for staff to use when certain risks were

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identified, for example, domestic abuse and child sexual exploitation. Staff knew how to identify when children required more specialised services and referred them appropriately.

- Therapists used ABC assessment tool to identify a delay or impairment in motor development in children and had developed care plan including skills programme with set timescales. This ensured children speech development was monitored and support provided as needed.
- Where risks such as swallowing were identified, care plans were not always developed to inform staff's practices and put children at risks of not receiving consistent care to meet their needs.

Staffing levels and caseload

- The report of our inspection, in June 2014, highlighted that the trust should consider the staffing capacity of health visitor service in order to deliver the healthy child programme effectively.
- At the time of this inspection, for children / young people and families services across the trust, there were a total of 519.40 whole time equivalent (WTE) staff members. In the previous 12 months 57 staff left the trust with a turnover of 10%. The registered nurse vacancy rate was 10% and nursing assistants 12% across the nursing teams.
- The trust had reached its trajectory of health visitors in Portsmouth of 60.5 WTE, in Southampton it had achieved 65 WTE with a plan for 70 WTE for the recruitment of health visitors in line with the expected increase in workforce through the 'Call to Action; Health Visitor Implementation Plan 2011-15' by the 30th of September 2015. The trust told us the new trajectory for HV in both cities included a skill mix of health visitors and community staff nurses to enable savings targets to be achieved.
- Staffing in therapy and health visiting was identified as a risk on the trust's risk register. Health visiting caseloads varied from 300 per WTE to 750 per WTE. Staff said no other staff were used to backfill, as a consequence they were providing a limited range of service. This had a high impact on the level of care they could deliver and they targeted those children who were most at risk.
- The Community Practitioners and Health Visitors Association (CPHVA) recommend caseloads for health visitors should be a maximum of 400 in the least deprived 30% of the population and ideally 250 per WTE

or less in the most deprived 20% of the population. Therefore the trust was not meeting this target. Staff told us the caseload weighting tool used by the trust was out of date as it was based on the trajectory and not the most recent indices of multiple deprivation. Senior staff told us this tool needed to be refreshed in order to accurately reflect the population it served.

- Staff told us in two areas in Southampton there were very high caseloads of 700 children of four years and under. In March 2016 staff wrote to managers reporting their concerns and completed incident reports about the impact of lack of staffing on children's services. Some bank staff was allocated in May 2016 in order to alleviate the pressure.
- In some school environments staff told us they felt they could not take time off work when they were sick due to staffing pressures. The manager told us they had identified two children's community nurses to cover school sickness from September 2016.
- The identified shortfall in health visitors and therapy staff; the lack of up to date caseload weighting meant that the trust could not be assured that there were sufficient staff to meet the needs of children and directly impacted on the safety of the service they provided.
- The trust told us that shortage of therapy staff and providing cover for member of staff on long term sick leave was stretching resources to other areas meant they had to re-look at caseloads.
- The trust had a mitigation plan for the shortfall in health visitors and recruited six community staff nurses in both Portsmouth and Southampton who were currently undergoing a six month induction at the time of the inspection. The trust told us these staff would undertake the five Healthy Child Programme reviews for those families receiving the universal service.
- Feedback from staff during our focus group meetings and from the monthly locality manager's report highlighted staff had been working excessive hours. For example therapy staff had worked 10 hours days and asked to carry out other tasks at short notice such as identifying documents for scanning. All had contributed to increase level of stress amongst staff.
- The school nursing team in Portsmouth had three senior nurses, and five school health nurses supported them to cover 69 which included specialist schools requiring higher level of input across the city. One senior nurse was due to leave the trust on the day we visited and one school health nurse was seconded to training. Only

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senior nurses were allocated a caseload of schools. Senior school nurses managed between 26-30 schools on their caseload. Staff told us they had 32 schools on their caseload; this was difficult to manage and had an adverse impact on children and young people. They did not have enough time to engage with every school on their caseload and some school were not aware of who their school nurse was.

- A locality manager of Portsmouth school nurses told us they had added staffing to the risk register and public health nurses would work across the health visiting and school nursing teams to address staffing issues. School health nurses were aware of this plan but did not know how it was going to work in practice.
- The public health nursing team in Southampton had six senior public health nurses and one vacancy for a public health nurse. Caseloads varied depending on the size of the school, one nurse we spoke to managed 14 schools. The variance in caseloads we were told added extra pressure on the staff and raised safety issues.
- Across both teams, staff spoke about shortages of staff having a direct impact on the amount of time they could dedicate to children and young people in schools. Staff told us their time was taken up with managing safeguarding and administration tasks limiting time to engage with children and schools. In some cases vaccination clinics were cancelled due to staff shortages.
- In all areas we visited, therapy staff spoke of staff shortages, which led to longer waiting times for children and young people. This was supported by parent's feedback and by external stakeholders. The trust had identified therapy staff shortages on their risk register
- In Portsmouth, we saw evidence of an action plan where physiotherapy staff prioritised the most urgent work during staff shortages. This was colour coded on a red, amber, green basis. Red status meant the service was

2.5 full time members of staff short, amber status was up to 2.5 members of staff short and green status was full staffing. The service was currently on red status as it was short three full time members of staff and staff told us from end of June 2016, they would be short of four full time members of staff.

Managing anticipated risks

- There was an embedded lone worker policy for staff working in the community. Risk assessments were carried out by staff prior to visits. Staff had mobile telephones and used 'buddy systems' if working alone that included a computerised text system linked to electronic diaries or staff would visit.
- The trust had a lone worker policy, which staff were aware of, staff informed colleagues of their schedules, staff were aware of each other's whereabouts and all staff working in the community had a work mobile phone. Some staff had access to a system which recorded their location and could be used to alert and summon help.

Major incident awareness and training

- Staff were aware of the trust's major incident plans but did not know if these were specific to children's services. However staff told us of an example of a power failure and back-up system which worked.
- At the time of the inspection there was a business continuity policy dated July 2015 with guidance on levels of incidents and delivering on critical activities but this was not service specific. This did not look at staffing, or what basic level of health visiting, school nursing or community nursing would be covered. A major incident 2014 policy was in place and due for review in 2017. The trust has since provided us with business continuity plan relating to paediatrics.

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

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

We rated effective as requires improvement because,

- The new birth visit and child development assessments targets for new parent and children were not met and were below the England average.
- Health visiting staff told us they had supervision but this was not consistent across all services due to staff's shortages.
- Appropriate pain assessment tool was not used to assess children's pain and particularly those who were unable to communicate their needs.
- Children's weight was not monitored and they were not regularly weighed to ensure they received appropriate pain relief as medicines dosages were calculated according to weight.
- There were limited updates and competency assessments undertaken in the schools where non clinical staff undertook clinical tasks.
- Staff's supervision process was inconsistent and practices were not monitored.
- Staff could not always access patient information when needed due to IT issues

However,

- Care and treatment took account of national guidance, such as National Institute for Clinical Excellence (NICE) guidelines and other pathways as recommended. This included the healthy child programme, baby friendly initiatives.
- There was effective multi-disciplinary working to meet the assessed needs of children and young people.
- The Family nurse practitioner had achieved the baby friendly breast feeding accreditation.
- Staff assessed children's nutritional needs and swallowing risks and detailed reports were available.
- Care pathways included language disorder, stammering and dysphagia pathways which were developed and were research based.

- The SLT team had developed colour coded and individualised place mats for children who had specific dietary requirements in line with SLT assessments. Staff told us this worked very well.
- The flu vaccine programme included children in year one to three.
- Immunisation rates were above expected targets.
- Staff felt they were supported and had received an appraisal and training.
- Staff followed guidelines ensuring children rights were protected and consent to care was managed effectively.

Evidence based care and treatment

- Health visitor teams used the "Ages and Stages Questionnaires" (ASQs) at the one year and two to two and a half year health reviews. The ASQs are an evidence based tool used to identify a child's developmental progress and provide support as needed to parents.
- Staff used Leicester height measurement for standing young children and toddler and also paper tape measure, as per Royal College of Paediatrics and Child Health recommendation.
- The health visiting service in both cities and family nurse practitioner (FNP) service had achieved the UNICEF and World Health Organisation (WHO) final stage 3 baby friendly initiatives (BFI) breast feeding accreditation. This is an evidence based approach to support breastfeeding by improving standards of care and support.
- The trust carried out a yearly audit to ensure they complied with the standards set by BFI carried out an audit stage 3 assessments involved assessing that mothers were supported with feeding so they could continue to breastfeed for as long as they wished and that they had been given useful, accurate information.
- Therapists used best practice messy play session-signing and picture exchange communication system (PECS) as part of their assessments.
- Health care professionals were aware of and cited best practice guidance and research they used in their specialist areas whilst providing care, treatment and

Are services effective?

support to children and young people. For example, the trust undertook an audit of feverish illness in the under-five with the children outreach assessment support team (COAST).

- Care pathways included language disorder, stammering and dysphagia pathways which were developed and were research based. This included picture exchange communication system (PECS), the east coast outreach system (EKOS) and therapy outcome measure such as stammer.
- In the Southampton public health nursing team there was a practice development group focused on using evidence to develop the service. We saw evidence of specific care pathways that had been developed to incorporate the National Institute of Health and Care Excellence (NICE) guidelines and were in line with the Healthy Child Programme. There were six care pathways; alcohol and substance misuse, sexual health, children with complex needs, emotional wellbeing, and healthy weight and stop smoking. These were in developmental stage and required quality assurance process and had not been implemented in practice.
- We saw evidence of the Healthy Child Programme for children aged 5-19 had been implemented in Portsmouth and Southampton. This included immunisations, screening, National Child Measuring Programme and health questionnaires given out to year 7 children who could request to see the school nurse to discuss their responses.
- The flu vaccine programme had been extended to include children in year 3, which meant all children in year 1, 2 & 3 would be offered the nasal flu spray as per guidelines.

Pain relief

- Children were prescribed pain relief and this was available to them as needed. In community setting, the nurses requested pain relief from the children's GP as required. Staff told us this process worked well.
- The vaccination and immunisation team offered advice to young people on the safe use of paracetamol in case of pain or fever post-immunisation.
- We saw in schools, pain relief was prescribed according to the child's weight. However the children were not weighed at regular intervals and any variation in the children's weight was not reviewed or recorded. We looked at a random sample of children's pain prescription and found four out of the five children were

receiving inadequate pain control compared to their weight. The school nurse told us children were weighed at the beginning of term and any weight lost or gained was not identified. This impacted on children as they may not receive adequate pain control to meet their needs.

- School nurses confirmed there was no nationally recognised pain score tools used. This would be appropriate for patients with a learning difficulty and those with limited communication, and could impact on the delivery of effective pain control at the right time to manage pain.

Nutrition and hydration

- Staff supported breastfeeding one to one with parents and were able to signpost families to regular breastfeeding support groups in local facilities. Parents could book onto introduction to solids sessions. Parents were positive about the help and support they received with breastfeeding across the localities.
- Children's nutrition and hydration needs were assessed and planned with input from a dietician. We observed dieticians participating in multi-disciplinary team medicals at Rosewood school. Nutrition and hydration needs were also included in the child's care plan at the schools for children with complex needs we visited.
- The paediatric speech and language therapy teams were also involved closely in the care and management of children who had additional feeding and drinking needs.
- Rosewood school staff followed the World Health Organisation (WHO) weight charts for boys and girls. Records showed the children's weights were measured at the beginning of term and staff told this would usually be in September. This meant it would not be done for a year; the risk of weight variation may not be identified in order to be managed effectively.
- At Rosewood school, the SLT team had developed colour coded and individualised place mats for children who had specific dietary requirements in line with SLT assessments. Staff told us this worked very well.
- We saw children were supported and received their fluids for example in adapted cups as identified in their SLT assessments. Staff we spoke with were aware of the types of fluids the children were prescribed. A senior staff said detailed care plans would be developed when we raised this with them at the inspection.

Are services effective?

- We saw an example of a health promotion poster giving information about how much water to drink.

Technology and telemedicine

- All community staff had been issued with laptops to record care given.
- The health visitors were in the process of developing a weaning e book (red personal child health record book) Healthier Together Wessex website. Also an application 'improving the health of children and young people' for parents and carers, children and young people and health professionals & Facebook.
- Parents at Rosewood school told us they valued having email contact for paediatricians as this made getting information about their child's care easy and efficient.
- A senior public health nurse in Southampton told us about the development of a Facebook page for school aged children and young people. This would include information from NHS choices and the change for life programme. The manager of the public health nurses told us the service was currently working with their communication team to implement a snapchat page.
- Southampton public health nursing team also told us they were looking at joining with Wessex Healthier Together project to develop a live website and application.

Patient outcomes

- The Healthy Child Programme stipulates that a new baby review should take place by 14 days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding and how to reduce the risks of sudden infant death syndrome. Senior staff told us they were unable to deliver this service within the recommended timescale due staff shortages. These included new born visits and health and development reviews which were not fully completed. In both Portsmouth and Southampton, new birth visits were below the England average.
- Health visitors carried out a perinatal audit in 2015 looked at the percentage of women registered with a GP in Portsmouth area. The audit looked at health visitor mood assessment and compliance with the perinatal mental health pathway. This showed that 100% of women were offered a maternal mood screen. For those identified with low mood, 100% were offered

appropriate follow up such as listening visits , GP referrals or referrals to "Talking Change". This is a free service providing support and treatment for people experiencing mild to severe anxiety and depression.

- A new role for an immunisation lead nurse had been developed within the school nursing team to work across Southampton and Portsmouth in September 2016 and improve uptake rates. The immunisation uptake rate for the nasal flu vaccine was 59% in Southampton and 65% in Portsmouth which met the target of 40%.
- Child health information showed the health and wellbeing of children were not being effectively met such as testing for HIV. Health visitors told us it was challenging to meet the needs of the many families with complex needs.
- In health visiting records we found there were progress notes with a brief plan of action but no evidence of care planning or involvement of parents. This was due to current staff vacancy and unfilled posts and the trust had put an action plan in place.
- Staff across Southampton and Portsmouth found it challenging to reach children and young people who were home educated as the local authority was unable to pass on details of these children. In Southampton, staff told us a public health nurse was working with the Southampton home educational support service (SEEDS) to try to engage with children and families who were home educated.

Competent staff

- Information provided by the trust showed up to February 2016, a total of 542 staff had completed an appraisal, with 27 staff's appraisal outstanding in the last 12 months. Staff commented that their appraisals were useful and two way discussions with their manager. Across services for children and young people 95% staff had completed an appraisal which was in line with the trust's target.
- There were systems in place to ensure staff received an annual appraisal from their line managers. However supervision of staff across the services was not consistent and competency assessments were not completed for staff undertaking extended roles. The trust could not be assured staff were competent to deliver up to date care as part of their extended role.

Are services effective?

- The number of non-medical staff who had received an appraisal was 95% up to February 2016.
- Staff told us it was hard to access face to face training due to pressure of work commitments. Staff commented that induction was good and they had received a folder with information on policies and services.
- Health visitors told us they received management supervision every six weeks and clinical supervision every three months. The Family nurse practitioner (FNP) supervisor had weekly supervision with FNP nurses, monthly supervision with psychologist and bi monthly with safeguarding supervision with named nurse safeguarding. They told us this helped in improving practices and learning across teams.
- Data from the trust regarding staff's supervision up to March 2016, showed supervision rates for health visiting and school nursing services were low and recorded at 65%. The trust told us this was identified and related to issues with some of the team in the cities and action taken. Community children nursing 86%, family nurse practitioner 95%, looked after children 75% and the community medical service Portsmouth and South East Hants 98%. Overall, this was below the trust target of 95%.
- The trust was developing some nurses to assist health visitors in the delivery of the Healthy Child programme. We were told this would be competency based and health visitors would be responsible for managing them. There were concerns among professionals about the skills of these nurses and their impact on care. Some staff said they believed these nurses would work under the supervision of the health visitors.
- At Mary Rose School, the nursing team assessed competencies of education staff on enteral feeding, tracheostomy care including suction, nebuliser administration and tracheostomy tube and tape changes, oxygen saturation monitoring, oral suctioning and ventilator use. We saw evidence of 57 completed competency assessments for education staff at the school.
- At Rosewood school we found health care assistants were undertaking some clinical tasks such as administering medicines and gastrostomy (a feeding tube inserted in the stomach) care. However these staff had not received up to date training and competency assessment for undertaking these procedures. Records showed care assistants had last completed training in 2008 and there were no competency assessment and framework to assess their competency. This meant staff were delivering care without appropriate training and could pose risk of children receiving outdated care and practices.
- The manager of nurses in both schools told us they had not checked individual staff's competencies due to time pressure. A competency assessment booklet had been produced and distributed to staff and planned to start in September 2016.
- In Cedar school health care assistants had completed gastrostomy and nasogastric feeding competency and a medicines competency as part of their internal assurance of safe care delivery.
- One healthcare assistant told us they had recently moved teams to help ease staffing pressures, however did not receive any additional training for this role which they said would be useful.
- Not all healthcare staff based in schools received regular supervision. Some staff based in Cedar and Rosewood school did not have regular clinical or safeguarding supervision. They also told us they were not offered bereavement or debriefing when a child died. At Mary Rose school in Portsmouth staff told us they had monthly supervision from their manager and there was a log to keep track of this. There was no audit carried out and we were unable ascertain the level of staff had received supervision. Supervision was not carried out on site which meant staff's practices were not observed such as medicines management.
- The public health and school nurses in Portsmouth and Southampton received annual training on immunisations and anaphylaxis (adverse reaction to drugs). They also received updates on other topics such as asthma and diabetes.
- Public health and school nurses received regular clinical and safeguarding supervision at 6-8 weekly intervals. In Portsmouth, occupational therapists told us they received supervision every 6-8 weeks with occupational therapists across the city. Staff told us they valued the opportunity for peer support and it was an essential tool to carry out their job.
- All staff we spoke with told us they had annual appraisals carried out. One nurse in Southampton told us they carried out appraisals for junior staff. The staff member had received appraisal training but commented it was not always relevant to practice.

Are services effective?

- The trust confirmed that doctors' revalidation process was in place. The child and family management and FNP teams had achieved 100% and Paediatric Medical Portsmouth and Southampton had achieved 91%. Revalidation is a process for staff to demonstrate they are up to date and fit to practice.

Multi-disciplinary working and coordinated care pathways

- There was good multidisciplinary work across services. For example, in Portsmouth the children's community nurses received referrals from a number of sources that included the local trust children's ward and accident and emergency department, the walk-in centres, GPs and self-referrals or for children with learning difficulties; joint visits could be arranged with the social worker.
- The children community nursing team, the CN, COAST and continuing care team felt they had good relationships with the local trust in Portsmouth and assessment unit, and GP's where they held liaison meetings. In all teams we visited, we saw excellent multi-disciplinary team working. The team had links with Health Visitors and felt they had an awareness of the service and they supported student nurses which also helped raise awareness and looked at practices. They said communication was effective and they had regular team meetings and links with staff in hospitals and specialist nurses.
- Education and health staff in Mary Rose School, Cedar school and Rosewood school spoke highly of the integrated working between professionals to develop child focused care. The therapy team in Rosewood school had provided training to education staff on using physiotherapy and occupational therapy in their daily interactions with children.
- Education and health staff contributed to care plans. The model of integrated working developed at Rosewood school had been the focus of articles in two national physiotherapy publications and in national education press. The head teacher at Rosewood school told us there were now approximately 30 schools following the model.
- In all schools we observed multi-disciplinary clinics involving paediatricians, physiotherapists, occupational therapists, dieticians, and speech and language therapists.
- The immunisation lead for school and public nursing had engaged with head teachers and GPs to raise the uptake rate for immunisations.
- Health visitors told us there was minimal support from other agencies for families with high needs and with safeguarding concerns. This was due to a lack of engagement from the social work team, families were not allocated social workers, and there was poor attendance at review meetings, which may have led to children being taken in the care of the local authority.
- In the teams we visited staff told us about a recent move to multi-agency teams with staff from other disciplines such as social care, therapy, health visiting and school nursing. Although staff told us they found this difficult at first, most staff reported it was a positive move. Some staff in more specialised areas such as staff working with children with complex disabilities told us they had not found it beneficial, as the professionals they liaised with were not included in these teams.

Referral, transfer, discharge and transition

- The Children's Outreach Assessment and Support Team (C.O.A.S.T), a team of experienced children's nurses, assessed and provided support and care to children from 0-16 years that were registered with a GP. They followed strict referral criteria for accepting referrals and had clear pathways regarding treatment they provided to children in their own home. This service impacted positively in preventing hospital admissions.
- The child health information system allocated new born children who were resident in the area or registered with a GP, to the relevant health visiting team. The trust had protocols for health visitors and school nurses for when children moved who were new to the area and a policy for those children who did not attend appointments or whose parents could not be contacted. There was a pathway for when children transferred from the health visiting service to the school nursing service and for when children moved out of the area. This was a means of monitoring children in the community.
- When children were discharged from treatment or care, the children community nurses in Portsmouth area told us they had good links with the local trust and they were notified. This meant staff were kept informed of children and young people's needs on discharge and were able to offer support appropriately. The children's

Are services effective?

community nursing team in Portsmouth attended meetings at the trust and were proud of the links and joint working where discharge planning were discussed. However in Southampton this was not well developed.

- One of the public health nurses told us they had difficulty in getting referrals accepted for the Child and Adolescent Mental Health Service. Although a duty line was available for staff to access advice referrals were often rejected. Staff we spoke with did not know whether this had been escalated to senior management.

Access to information

- An electronic record system was being introduced across the trust, and the level of its integration varied within localities and teams. As a result, both paper and electronic record systems were being used.
- Staff had raised concerns about the accessibility of the new IT system. In Cedar school the therapy staff were had no access to IT and we were told although this had been escalated nothing had happened and caused staff frustration and stress.
- Staff in community locations told us about difficulties accessing patient information via the trust's new IT system. This prevented staff from accessing patient information electronically. In Rosewood school during the inspection we found all the healthcare staff had been 'locked out' of the system and were told they had to visit an NHS site to resolve this. This meant staff did not have access to any of the trust's electronic records, policies or incident reporting system. Staff told us they had raised this issue with the trust.
- Staff also raised concerns about the IT system as components were added and staff had not received training in order to effectively use the system which impacted on their work and access to information.
- The trust had started a process of scanning records on to the new IT system. Staff including doctors told us the scanned records were not easy to find as they did not follow a format similar to the paper records. For example, the trust's electronic system was unable to connect to the GP's electronic system. There were problems reported in accessing records for 5-11 year olds. This was not on the risk register. Staff told us children's records were missing on the electronic system and there were delays in getting them added. This may impact on care provision as records may not be available when needed.

- The children looked after safeguarding (CLAS) report May 2016 identified concerns with IT system which did not reflect key learning from national serious case reviews. Also details and information about children were hard to find. Alerts were not put onto the system routinely to immediately advise practitioners and managers to the presence of children in a case and this clearly elevated risk that child welfare may not be prioritised.
- The CLAS report also highlighted the difficulty in obtaining a comprehensive overview of events within the family as the trust's policy of not uploading child protection conference minutes and plans onto the service user IT record system. The trust told us this was not policy but local decision following consultation with information governance lead. The relevant information was copied from meeting minutes into the child's record and an alert was provided directing staff to where they could access the full minutes if required.
- There were currently different systems in use which were not compatible and staff told us was "challenging" in securing information in a timely manner.

Consent

- There was a process which staff followed in gaining consent for care and treatment, and for information sharing with other health and social partners where appropriate. Staff ensured children were engaged and age and capacity appropriate consent was sought as needed. We observed this process on a number of occasions and we found children wishes were taken into account such as listening to their chest or assessing their technique when using inhalers.
- At one of the schools we visited staff told us they would follow the school's policy on resuscitation. This meant they would not follow any advanced care planning for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). Staff told us they followed the school's policy to attempt resuscitation of all children in an emergency. This included even if an order was in place such as an advanced directive and plan. The trust has since told us they had a unified advance care plan developed in conjunction with schools.
- Young people could self-consent to have the Human Papilloma Virus (HPV) immunisation if they were deemed to understand the risks and benefits of having

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the vaccine. The self-consent form included an assessment of the young person's understanding. Young people were given an information leaflet and presentation to aid understanding of the immunisation.

- Community staff and nurses had an understanding of the use of Gillick competency and Frazier guidelines in relation to consent. Gillick competency guidelines refer to a legal case which looked at whether doctors and healthcare professionals should be able to give advice

and treatment to under 16 year olds without parental consent. They are used widely to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

- Mental capacity training was not part of the induction mandatory training for staff.
- We observed community nursing staff sought consent from children at all times prior to undertaking any examination and with parental involvement as appropriate. This was managed effectively with due regards to their wishes.

Are services caring?

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

Summary

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

We rated caring as Good because:

- Staff treated the children with respect, care and compassion at all times. Feedback from people who use the service, those who are close to them and stakeholders is continually positive about the way staff treat people. People think that staff go the extra mile and the care they receive exceeds their expectations.
- Children were put at the centre of their care and staff used diversion and play when providing care and sometimes in difficult circumstances to ensure best outcomes for them. Parents and carers were overwhelmingly complimentary about the care and support they and the children received.
- It was evident from the interactions observed on the visits with the COAST teams, community visits and 'Trache' bus that staff had developed excellent relationships and trust with the children and their families and they felt valued.
- Staff took time and ensured children and parents were fully involved in their care and used strategies to meet their individual needs.

Compassionate care

- Care was provided in a caring and compassionate way where the children were put at the centre of their care. We observed multiple interactions with children and their families. During one home visit, we observed the nurses using diversion to pacify a child and at various times paused throughout the treatment ensuring the child was calm before resuming treatment. Staff used diversion on several occasions such as play, sing song, choosing the child's favourite programme to gain their trust and cooperation with excellent results.
- Staff took the time to talk with the children in a calm and compassionate way and at all times staff positively interacting with them including in difficult situations and yet remained patients' focussed and caring. It was evident from interaction that children had developed trust in the staff that supported them.

- We observed a child who was agitated and distressed. At all times staff provided care and support in a calm and compassionate way by speaking with them calmly and providing constant reassurance.
- At Mary Rose school we observed children were treated with care and kindness. A child was supported in a compassionate way when they sat on the floor while moving between classes. The staff member allowed them to sit on the floor ensuring they were safe; this was used as a game "having a little rest and then we will go again".
- Children's individual needs were known to the staff and care was provided in a compassionate manner. On a home visit, the nurses providing chemotherapy treatment to a child carried out all the preparation and filled their syringes in the kitchen out of sight so as not to cause distress to the child. Care and treatment was provided in a calm and unrushed way. Parents commented they would not be able to "carry on without the care and compassion from the nurses."
- On the interactive Trachey bus we observed excellent interaction between the staff and the children. Staff used music and read stories to the children and ensuring each child received the same level of compassionate care and attention. This was particularly empowering as the children were unable to speak and staff used different means to communicate with them such as signing and Makaton. Staff had extensive knowledge of the children's preferred songs ensuring children were central to their care as they travelled home. This included a song they had made up about the Trachey bus which the children clapping their hands with joy when they started singing the song. This further demonstrated individualised care and putting children at the centre of what they did.
- Staff provided support to the children and their parents but also had developed relationship with their siblings, involving parents and carers in the care as appropriate and including siblings to choose stickers.
- In all areas we visited staff provided treatment and care in a kind way and treated people with respect. All parents and carers we spoke with were positive about how staff had treated them

Are services caring?

- The NHS friends and family test results showed that 96% of people would recommend children's services to their friends and families. The NHS friends and family test is a survey, which asks patients whether they would recommend the NHS service they have received to friends, and family who need similar care.
- We observed good interaction between staff and children and young people. Staff made good eye contact with children, introduced themselves and explained what was going to happen.
- Staff focused on children and young people as individuals. We observed an occupational therapist transferring a five-year-old child in a hoist, tapping the child's shoulders (their means of communication) to inform them they would be raised and placing their hand underneath the child's legs to let them know they would be lowered.
- We saw staff using screens to protect the dignity of children and young people during examinations.

Understanding and involvement of patients and those close to them

- Parents were overwhelmingly positive about the care their children were receiving. They felt fully involved in the care and treatment of their child and appreciated being treated as equals.
- We observed on several occasions, care being provided in children's own homes by the specialist nurses and the community nursing teams. For example the asthma nurse engaged the children fully involving them in their care. This included age appropriate information shared with the child such as pictures showing how taking their inhalers correctly helped to (open their breathing tube in their lungs). Another child was given a chart to use as an aide memoire for recording their inhalers, effectively putting the child in control which they thought was "brilliant".
- Parents and carers comments included they had never before received such good information from staff in understanding their children's care and how best to support them.
- Other comments included that they thought care and involvement was "brilliant and can access so much" and "happy with everything" from a parent at a breastfeeding group.
- The parents we spoke with felt the team involved children and young people in their care and ensured

- their care needs were met. Education staff also supported this describing how health staff communicated directly with the child to ensure they understood exactly what was happening and why.
- During a National Child Measuring Programme clinic at an infant school we observed staff interacting with children and explaining weight and height measurements in age appropriate language. Staff made eyesight and hearing tests into a game and we observed staff giving children praise and encouragement throughout the tests with positive impact.
- We observed a physiotherapist moving a child; they explained how they were going to assist them to move such as on the count of three and encouraged the child to count down at the same time.
- We observed a clinic appointment where staff offered to introduce parents to another young person and family who had undergone similar surgery to help support the young person and family.
- A young person with physical disabilities told us they recently required catheterisation on a regular basis. They told us the school nurse had worked closely with teachers to train them in catheter care meaning the young person was able to go on school trips and taking control of their life and had recently attended a residential setting.
- Parents spoke highly of the multi-disciplinary team at the schools including paediatricians, nurses, dieticians and therapy staff. Parents told us their questions were answered and feedback and communication was excellent

Emotional support

- We observed clients being supported emotionally. A maternal mood review was offered postnatally to assess emotional wellbeing of new mothers following childbirth. Nationally 10% to 15% of all postnatal women will suffer from mild to moderate depression with the majority being supported by their GP and health visitor. For those who required more intensive support the trust provided a perinatal mental health service.
- Parents had access to post-natal groups in local venues that offered social interaction and parenting information and support for parents with young babies.
- Mothers comments included; "Took a time to get breastfeeding established, wouldn't have continued without their support".

Are services caring?

- During a multi-disciplinary team medical, staff observed the child throughout a physical assessment for signs of pain and distress. When the child started becoming unsettled the paediatrician stopped the examination to prevent any further distress
- We observed staff playing music to a child who was distressed after having a seizure. The music immediately calmed the child.
- In Southampton, staff told us about the collaborative working between public health nurses and no limits workers to ensure a holistic approach to health and emotional well-being.

Are services responsive to people's needs?

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

Summary

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

We rated responsive as requires improvement because,

- The trust was not consistently delivering the healthy child and the education and healthcare programmes such as new birth visits and child development assessments
- There was a decline in the percentage of parent and babies who were receiving the new birth visits within 14 days. The trust was significantly below the target of 90% and this was due to staff shortages.
- Staff currently did not have the capacity to complete public health plans in schools, some of these plans were based on a targeted risk based approach.
- There were delays in responding to requests for contributions to the education health & care plans (EHCP) process.
- The children continence service was not fully developed and there was currently no paediatrician input in clinics which were nurse led and children were referred to general paediatric clinics.
- The referral to treatment time of 18 weeks was not consistently achieved in Hampshire therapy service due to unfilled posts which impacted on care delivery.
- Children had long waiting times for wheelchairs which impacted on the safety and well-being of children in the community settings.

However,

- There had been an improvement in the assessments of looked after children who came into care such as 87% of children receiving immunisation close to the trust's target of 95% .
- There were processes in place to meet the diverse needs of children and young people. This included access to services for people with mobility problems and a face to face translation service.
- Staff followed the internal process for responding to concerns and complaints and learning from these were shared.

Planning and delivering services which meet people's needs

- The trust had in place a joint strategic needs assessment to plan and deliver services overall. These included developing a business plan to expand OT services to meet the diverse needs of children such as those with autism and attention deficit hyperactive disorder (ADHD).
- Demographic information showed children fewer than 16 who were living in poverty was 11% in Hampshire. While this was 22% for Southampton and Portsmouth which was above the England average of 18%. Health visitors told us they were unable to work proactively and in a preventative way with families, but mostly in a reactive response to high levels of need and safeguarding and lack of resource.
- Community services, including those for children, young people and families, were reorganised into the current locality structure, to promote integration of physical and mental health services. As a result some services were relocated including the Northern parade Clinic which was no longer fit for purpose was also relocated to Battenburg Avenue clinic.
- Healthy Child Programme with its emphasis on the early identification of need and the support of families to improve health and wellbeing and reduce health inequalities. The Healthy Child Programme has a schedule of screening, immunisation and health and development reviews as set out by the Department of Health (DH). However not all elements of this programme were being delivered such as support to new mothers. As part of the Healthy Child Programme, health visitors should provide an antenatal visit at 28 weeks of pregnancy to pregnant women identified by midwives as needing extra support.
- Health visitors would also arrange to visit a new birth between 10 and 14 days postnatally, organise at 6 to 8 weeks post-natal review as well as health reviews at one year of age and two to two and a half years of age. However, antenatal visits/classes for all pregnant women where contact could be made with health

Are services responsive to people's needs?

visitors, were not scheduled across the trust as set out in the Healthy Child Programme. This meant the needs and support requirements of mothers and babies were not always identified at an early stage.

- Workshops were taking place between school nurses and community health staff nurses in the health visiting team to deliver the Healthy Child programme. This included immunisations, National Child Measuring programme and transition to services.
- The public health nurses in Southampton were working collaboratively with the No Limits service to deliver integrated health and emotional wellbeing to children in school. Services had joint recruitment, team meetings and supervision to ensure a collaborative approach.
- Staff were concerned that safeguarding priorities, large caseloads and shortages in staff numbers impacted on the delivery of the service. For example, the lack of health visitors, school nurses led to a targeted approach in the delivery of the service. Staff had raised this as a concern with the trust as they currently did not have the capacity to carry out all their public health plans such as sessions in schools.
- Children's services have a statutory responsibility to participate in the development of Education Health & Care Plans (EHCPs) for children and young people as part of the SEND reforms. Due to changes in personnel managing the process there have been delays in responding to requests for contributions to the EHCP process. This was highlighted in the trust's risk register; however there was no action plan developed to mitigate this risk.
- The children's continence service was not meeting the needs of the local population due to limited resourcing with only 0.3 WTE paediatric nurse specialist available. There was no children's continence service at the current time for children in Fareham, Gosport and South East Hampshire. Discussion was ongoing with the clinical governance group (CCG) to resolve this issue.
- The continence service did not currently have a paediatrician following a new pathway which came into effect in September 2015. The service is nurse led and there had been no paediatrician input in clinics for the staff, or to review patients as per the agreed pathway. The trust had highlighted this on their risk register. This was an ongoing issue which has not been resolved. The trust has told us children were referred to the general paediatric clinics as required.

- At the time of our inspection antenatal assessments were for those identified as universal plus and universal partnership plus and was not provided as a universal service for all pregnant women. Staff identified and referred those for whom they had concerns to health visitors. Therefore needs were not always identified early and support needed may be lacking. NHS England's guidance is that all families should expect an antenatal visit one of five 'universal health reviews'.
- Regular child health clinics were held across the region for parents to access advice and monitor the growth and development of their young children. Parents were also signposted to sessions, activities such as introduction to solids.

Equality and diversity

- All areas we visited were accessible for children and their families with a physical disability including designated parking facilities, entrance areas and toilets.
- There was a trust wide interpreter service available either face to face or via the telephone if needed for non-English speaking families. All staff we spoke with were aware of the service to meet the needs of the diverse population throughout the trust.
- Leaflets were available in English only and the leaflets did not indicate that information could be accessed in other languages.
- Staff had received training and used different methods to communicate with children such as signing and Makaton.
- An equality impact audit was undertaken in 2015 for learning disability services and looked at protected characteristics such as age, sex, disability and access of care from black and ethnic minority group. An action plan was developed such as building links with community champions and training and raising awareness. Some of these had been achieved and prompt cards devised with key points relating to faith and culture and work was ongoing.

Meeting the needs of people in vulnerable circumstances

- The British HIV Association (BHIVA) published "Don't forget the children" 2009 guidelines which recommended all new HIV positive patients attending adult HIV services should have any existing children identified and tested. The children's health could then be monitored and treatment offered as appropriate. The

Are services responsive to people's needs?

trust's audit in December 2015 showed had an increase in the uptake of this service. However the trust was not meeting the recommended period for testing of 6-12 months and took up to 24 months for children to be tested. This could impact on children not receiving advice, care and treatment in a timely way. Action plans had been developed which included raising this at multi-disciplinary team meetings and communicating with parents the importance of timely testing.

- The scores for a young person that was not in education, employment, or training (NEET) showed Portsmouth scored higher and was above both the South East and National averages. Portsmouth was at 7%, and had the second highest proportion of 16-18 year olds who were NEET and, at 18 %, the 3rd highest proportion of 16-18 year olds whose activity was unknown.
- The trust undertook a smoking cessation audit in January 2016 to assess if health visitors assessed the parents' smoking status. This showed smoking status had been recorded in 84% of cases. There were 28% of the mothers and 24% of households smoking, only 16% of records had documented that smoking cessation services had been offered and one referral had been made to smoking cessation services. An action was developed in October 2015; however there was no evidence of who would be responsible to complete this.
- The speech and language therapy team working in schools supported the teachers and provided them with vocabulary and communication symbols such as the picture exchange communication system to support children with a learning difficulty.
- Staff told us that they prioritised work with people in vulnerable circumstances and would see people at times and places convenient for the young people and parents or carers. All families, including those with No Recourse to Public Funds were offered the Healthy Child Programme and supported in accessing additional support through the third sector.
- Specialist health visitors working with children with complex disabilities who have contact with families every three months until completed end of reception year including signposting family, advising, supporting.
- In Portsmouth, we heard about a review of bullying and self-harm strategy for school-aged children. The school nursing team planned to work with schools to help implement this.

Access to the right care at the right time

- New birth visits (NBV) within 14 days were well below the 90% national target. This was due to health visitors' unfilled posts and caseloads. The latest data from the trust showed in January 2016 in Portsmouth 74% of babies had an NBV compared to average of 83% in the previous months. Between 15-21 days NBV was 20% which reflected an improvement and 3% of babies had an outstanding NBV. However there were 4% of babies who had not received an NBV over 21 days.
- For children living in Southampton for the same period this showed 84% of babies having an NBV within 14 days. Between 15-21 days NBV was 11% and 5% of babies had an outstanding NBV. There were 1% of babies who had not received an NBV over 21 days. In both Portsmouth and Southampton, new birth visits were below the England average.
- Staff were concerned that safeguarding priorities, large caseloads and shortages in staff numbers impacted on the delivery of the service. For example, the lack of health visitors, school nurses led to a targeted approach in the delivery of the service. Staff had raised this as a concern with the trust as they currently did not have the capacity to carry out all their public health plans such as sessions in schools.
- The national target for referral to assessment is for 95% of patients to be treated within 18 weeks. This was not achieved for the 18 week standard in the Hampshire Therapy Service due to staffing.
- Information from the trust indicated that therapy performance was declining month on month now for North Hampshire and West Hampshire localities. The 18 week target was not being met for the service as a whole and there were significant number of 18 week breaches, and in some cases, long waits. This performance was mainly down to a shortage of Occupational Therapists
- Therapists offered parents and children choice of venues if waiting list was high in a particular area. Children were also offered to continue at nursery if they had additional needs and complete reception year there.
- Statutory guidance states that initial health assessments for 'looked after children should be completed within 20 days of placement. The trust rate was 86% which did not meet the target of 95%.
- The looked after children (LAC) should have their health needs assessed in a timely way. Information we had

Are services responsive to people's needs?

received showed in Southampton 82% of young people coming into care were having their health needs assessed within target timescales, 80% were receiving dental checks and 87% have up to date immunisations, demonstrating significant improvement.

- Child health clinics ran throughout the week in various locations so that parents and carers could access them. Parents told us they were able to contact health visitors in a timely manner.
- There was no specific data for children and young people do not attend (DNA) rates. Staff said they did not know whether this was measured. Following the inspection the trust told us they had a “child not brought in” policy for “vulnerable” families and this was followed up.
- Feedback we received was that children in the community had long waits for wheelchairs, although provided by an independent contractor these were impacting on children receiving Solent services. The trust was aware of the issues and was in discussion with the provider but to date there had been little improvement.

Learning from complaints and concerns

- Complaints were handled in line with trust policy; and staff were able to talk through their process they followed and gave information on how to complain.

Staff directed patients to ‘Patient Advisory Liaison Service (PALS)’ if they were unable to deal with their concerns directly and advised them to make a formal complaint.

- For children, young people and families, the trust received 84 compliments from March 2015-February 2016.
- The trust received 31 complaints in the same period. Of these ten (10) were fully upheld and six (6) were partially upheld. One was referred to the Ombudsman and upheld.
- As part of the lessons learned, there was a process to share findings from the PALS and the complaints team who were responsible for collating this information across all service areas and reporting on actions initiated. The lessons learned were also discussed at their Quality Improvement and Risk meetings, Patient Experience Forum and at local clinical governance meetings. Staff we spoke with told us that feedback from these meetings was not always shared across teams for learning.
- We saw an example where staff had met with the family together with the lead for the service to address the issues and concerns raised. There was on-going discussion with the family and the lead will be investigating and report back for lessons learnt.
- We found that across the teams, the process for logging complaints was not consistent. Staff would record in patients’ records with no means of auditing in order to look for any trends and lessons learned.

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

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

We rated well led as requires improvement because,

- Not all risks were identified and there were not clear plans to demonstrate how these risks would be mitigated. This included some serious potential risks to children had not been identified.
- There was a lack of robust governance where risks were identified; action plans were not always clear with regards to responsibilities and ownership. Governance systems were immature and did not provide an appropriate method of assurance.
- There had been many recent changes in the staff's structure and there was a mixed view of the visibility of senior managers and the executive team. Staff felt the level of changes which had resulted in the loss of experienced staff had not been well communicated and managed. This included staff shortage in certain services which impacted on the delivery of care.
- There was no system for engagement with children and carers in order to seek their views about the service they received.

However,

- There was a service strategy for paediatric, health visiting and therapy services which included development of carers' surveys and improving nutritional and breast feeding initiatives.
- Staff were committed to their patients with an inspiring shared purpose in providing care centred on the patients.
- Staff worked cohesively and they were passionate about the care and the service they provided. Patients' experience was seen as a priority and there was effective multi-disciplinary working to improve the care and wellbeing of children and young people.

- Staff felt valued by their immediate line management and well supported.
- Staff worked with the local community groups and raised funds to support local community and to meet the needs of children and young people.
- There were good examples of innovation and improvements to services.

Service vision and strategy

- The trust had a service strategy for paediatric, health visiting and therapy services which was linked to the trust's strategy. The children and young people's strategy included the plan to implement a carer's survey and information used to identify improvement plans. There were plans to review the trust's nutritional policy and deliver annual objectives in improving nutrition to be achieved by working within breast feeding initiatives. Another area identified was to enable children to be involved in their end of life plan and development of children information library on the trust's website.
- The service was going through a period of transformation as part of integrated care strategy. During this time staff had experienced changes to the way in which services were delivered. For example, the re-organisation into localities had been challenging for staff and had resulted in the loss of experienced staff in some services.
- Staff were not able to effectively deliver the health promotion aspect of the healthy child programme due to capacity which staff said were not addressed in a timely way and these included health visitors and therapists
- The trust's vision remained clear "to provide high quality services that deliver care for people and communities". This vision was underpinned by a set of values and objectives; however the governance processes were not sufficiently robust. For example, clinical supervision did not always provide clear insight into the actual provision of care delivery.
- The vision and values were known by staff and staff were recently issued new lanyards which highlighted those values and these were on display in the areas that we visited.

Are services well-led?

Governance, risk management and quality measurement

- The trust maintained a corporate risk register report that, at the time of inspection, included a total of 10 risks and these were for children community health services only. The risk register was not consistent with staff concerns and the risks we identified during the inspection.
- The high risks relating to medicines management at one of the specialist schools had not been identified as part of the trust's risk management process. This included care practices which were not in line with NMC standards. The governance process was not robust in order for action to be taken and mitigate the risks. The quality assessment system was not always able to appropriately measure outcomes due to unassessed risk and the management process did not identify area of substantial risk which we raised with the trust.
- At the time of our inspection, we raised urgent concerns with the trust regarding poor medicines' management at one of the specialist schools. Following our intervention, the trust's pharmacist carried out a review and assessment of practices and identified changes needed. We received an action plan regarding the steps the trust was planning to take to mitigate risks identified.
- The risks associated with different IT systems were not fully assessed or mitigated. Staff continued to raise concerns about access to records and possible delays to treatment as systems were not integrated. The community team used one system for creating and sharing electronic records, which was not used by some GP practices.
- There was no health visitor caseload weighting to ensure staff had the capacity to meet people's needs and ensuring this was reflected on the risk register. The volume of caseloads and unfilled posts impacted on the service provision and impact on children.
- The risk register included school nursing services experiencing high turnover of staff and long term sickness and had been on the risk register since February 2015. This continued to provide a gap in service provision and meeting the needs of the local community.
- The risk register showed currently there was no engagement from children's services to resolve the risk relating to continence service. There was no

paediatrician input to the children's continence service which was an on-going issue. There was no action plan to show how this would be resolved as currently the service was nurse led. This had been escalated to the board and on their risk register.

- There was a governance and risk with various working groups such as clinical audit and effectiveness committee which linked with the clinical governance committee. They looked at incidents and complaints. Information was shared staff meetings. However, the risks relating to medicines, equipment had not been identified
- There was a monthly business team meeting, which provided the board with progress being made against the trust's improvement plan.
- The trust took part in national audits and undertook local audits. Staff told us audits were discussed as part of MDT and team meetings, and action plans developed to address any shortfalls identified. However feedback was mixed about how lessons learned were shared among the teams.

Leadership of this service

- The majority of staff felt that communication from senior team regarding the recent review and amalgamation of teams had not been well managed. Staff told us they heard "lots of rumours" and also "denial by senior staff" that moves were not happening. Other concerns were the new way of working and staff were managed by senior member from other disciplines among therapy staff. They felt this was not an effective model and there were issues with knowledge base.
- Staff were clear about their roles and who they were accountable to and senior staff were accessible to teams.
- Staff described management at local level and support they received from their immediate line managers as very good. However they viewed management overall as top down with too many changes occurring at the same time. These included new IT system, locality and team changes and inadequate access and support. Staff described management as being "remote and felt they had not engaged with the staff and changes were "done to them".
- The therapy staff told us there had been some recent improvement and they had attended meetings to keep staff informed of the changes.

Are services well-led?

Culture within this service

- Staff spoke positively and passionately about the care and the service they provided. Quality and patients' experience were seen as a priority and everyone's responsibility. Staff talked about having an open culture in raising patients' safety concerns. However, there was a culture that did not always identify poor practice, such as medicines management which impacted on care delivery.
- Staff were supportive of each other and they felt they worked well as a multi- disciplinary team. Staff felt the changes into locality bases provided some challenges and this included maintaining staff's morale and "getting on with the day job".
- Staff viewed integration of health and social care as a positive step such as co-locating with the multi- agency teams in Portsmouth to support delivery of integrated children services.

Public engagement

- Currently there was no age appropriate survey in order to seek the views of children and young people using the service. Staff told us they were in the process of developing the "Monkey wellbeing feedback" for all children's services. Some of the staff told us this was "well overdue".
- Following the children safeguarding review and action plan in February 2015, this identified the need to re-evaluate safeguarding training on practice and a monkey survey questionnaire which had not been implemented.
- Staff at Highbury children centre worked with third parties such as Barnardos, food bank and the Salvation Army to support children and their families in the local areas.
- The children's and young people user strategy 2016-2017 included the implementation of a carer's survey and working with local authority to identify young carers. However there was no timeframe and it did not identify persons responsible to take these initiatives forward.

Staff engagement

- The most recent staff survey in 2015 showed a 20% response rate which was higher than national average. The results showed 46% of staff would recommend the

trust as a place to work compared to England average of 62%. This was overall data for staff working at the trust. There was no specific data for staff working in the community children, young people and family services.

- Senior managers told us, as part of the review of certain services there had seen a decline in staff morale. Moving forwards, they had identified corporate visibility at service level may help improve this. The Southampton care group performance review meetings were being relocated to Adelaide Health Centre to start this but further commitments will be required across the trust.
- There was a monthly newsletter for staff and this was displayed in the services we visited. This provided staff with news and kept them up to date with changes within the services.

Innovation, improvement and sustainability

- The interactive Trachey bus is one innovative service that has huge positive impact on the lives of children living in the Portsmouth area. Currently the Trachey bus can safely accommodate four children and facilitate these children attending school. This service was not available in the other local boroughs.
- The impact of the budget deficit from October 2016 and work plan indicated options such as recruitment of health visitors and training of nurses to support HVS in their role. There were concerns among professionals about the impact of this. This did not address accountability for these staff as per nursing and midwifery council (NMC) for delegated tasks.
- Staff said that improving the children's lives was the main focus of working for the trust. Solent speech and language therapy staff at the trust undertook an enhanced parent based intervention (EPBI) research pilot in 2015. This was based on previous research which had shown a correlation between early language difficulties and social disadvantage in children which had high risks factors for adverse outcomes later in life. The study found that early intervention and engagement with parents in disadvantage areas the uptake was higher. This service evaluation has shown that children living in a socially disadvantaged area could make language gains when parent attendance and engagement in intervention was facilitated.
- Following reaccreditation in 2016, the trust has retained its Investors in People Accreditation Health and Wellbeing Award.

Are services well-led?

- Solent trust planned to evaluate the children outreach assessment support (COAST) services to look at referral patterns, postcode trends, urgent care service users' demographics and health seeking behaviours.
- Staff in the Southampton public health nursing team had set up a Facebook and twitter page to engage young people in health promotion topics. The pages include material from NHS choices and the change for life programme. The nurse who set up the pages told us about a recent health promotion topic on the page aimed at encouraging young people to drink more water.
- At Rosewood school, education and therapy staff had designed a model to integrate therapy in everyday classroom activities for children with physical and learning disabilities. Therapy staff ran training for teachers to include therapy into the child or young person's daily routine. Staff told us they were very proud and positive about the model and articles had been published in professional physiotherapy and educational press. Staff told us 30 schools had adopted this model in schools providing care and support for children.

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care or treatment.

- Medicines were not always kept safe in some school locations. Medicines management was not consistently in line with current legislation in relation to administration, prescription and their safe storage. Regulation 12 (2) (g).
- Risks relating to medicines were not always fully assessed, monitored and action taken to mitigate these in order to safeguard the welfare and safety of people using the service. Regulation 17(2) (b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met: People using services did not have their needs met in a consistent manner.

- Staff receive such appropriate support, training, professional development, supervision as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2) (a)
- Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the needs of people using the service. Regulation 18(1)