

The Rotherham NHS Foundation Trust

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Community health services for children, young people and families

Quality Report

The Rotherham NHS Foundation Trust
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RFRHC	The Rotherham Community Health Centre		

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

We carried out this inspection because when we inspected the service in February 2015, we rated the service as requires improvement. We asked the provider to make improvements following that inspection.

At this inspection, we rated community services for children, young people and families as requires improvement because;

- Incidents were not always appropriately categorised or graded and we saw that staff within the service had a limited understanding of the duty of candour. The risk register was not always regularly updated or maintained and did not contain evidence that mitigating actions were regularly monitored. The trust did not routinely share learning from informal concerns. This had also been highlighted at our previous inspection.
- There was a risk that medical records were not contemporaneous. There was very limited use of telemedicine or technology to help in delivering effective care.
- School nursing staff told us they were carrying high caseloads and that staff had left since the time of our previous inspection. Our previous inspection also identified concerns about staffing and caseloads within the service.
- The service was failing to meet performance targets in regard to the national health child programme. Some services were not meeting referral to treatment target times for initial appointments and there were lengthy waits for appointments following initial appointments. These issues had also been highlighted at our previous inspection.
- There were limited examples of regular or robust audit or outcome monitoring in place to ensure that the service was assured it was providing effective care and treatment. This had also been highlighted at our previous inspection.
- There was a risk that trust policies and guidance did not reflect current best practice due to the number of policies and guidance documents reported as being beyond their review date. We saw a lack of child friendly leaflets and information available in clinic areas.

- The service was not meeting the needs of looked after children and there were delays in child protection information being available to staff. Patient information was not routinely provided in a range of languages. There was a risk that instructions on how to access information in other languages would not be understood by young people and families that did not speak English as their first language. This had also been highlighted at our previous inspection.
- The service had not yet developed a clear vision or strategy to reflect how services would be provided across the local area.
- Staff in the 0-19 pathway told us that they did not feel that feedback was valued or acted on in regard to the 0-19 tender process. There was a lack of formal public or staff engagement outside of the 0-19 tender process in order to drive improvements and make changes to services. Parents of children waiting to access services were unsure how to access emotional support and told us they felt they 'slipped between the cracks'.

However:

- Staff told us that there had been positive improvements in the culture within the service since our last inspection.
- The trust had made significant improvements to the medicines management and environment in the short break service. The trust had significantly improved the percentage of staff undergoing a formal appraisal. The trust had also taken steps to ensure that access to child and adolescent sexual health services were available to young people outside of school term times.
- Safeguarding and mandatory training figures were also high. Staff were receiving clinical and safeguarding supervision, although this was not always done in the manner outlined in trust policies.
- There was effective multidisciplinary working amongst different teams within the service and wider health and social care services. Services were planned to meet the needs of children, young people, and families. Regular team and service level meetings took

Summary of findings

place to allow governance issues to be discussed and we saw learning from formal complaints was shared with staff. Staff spoke positively about the support provided by their teams and immediate management.

- Children, young people and their families told us that staff were caring and supportive and we observed staff providing kind and compassionate care. Staff involved

children, young people, and their families in care planning and provided tailored advice and guidance to ensure clinical needs were understood. The service received consistently high scores in the NHS Friends and Family Test and we saw that staff treated children, young people, and their families with dignity and respect.

Summary of findings

Background to the service

Information about the service

Community health services were transferred from the Primary Care Trust to The Rotherham Hospitals NHS

Foundation Trust on 1 April 2011. Services for children, young people and families delivered services to a population of around 63,500 children and young people aged 0-19 years old in the Rotherham area. This equated to approximately 23.5% of the local population. Of these, an estimated 5,861 school aged children were from BME groups.

Community health services for children, young people and families delivered by the trust included: child development assessment, physiotherapy, occupational therapy, speech and language therapy, contraception and sexual health services, family nurse partnership, health visitors and school nurses. There were specialist services, such as the short break service and youth offending.

We previously inspected the service in February 2015 and rated the service as: inadequate for safe, requires improvement for effective, responsive and well led, and good for caring. At that time we made a number of recommendations to the trust to set out what they must and should do to improve.

At the time of this inspection, the service had recently won a new tender to provide 0-19 care within the Rotherham area. This had involved consultation with staff and proposed changes to service provision. In addition, the trust was in the process of merging the child and adolescent sexual health teams with the adult genitourinary medicine service. This was also open to consultation.

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Nurse Director

Head of Hospital Inspection: Amanda Stanford, CQC

The team that inspected community health services for children, young people and families included CQC inspectors, health visitor and a community children's nurse.

Why we carried out this inspection

We inspected this core service as part of our responsive, follow-up inspection.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit on 27 to 30 September 2016.

Summary of findings

During the visit we talked with staff and people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

What people who use the provider say

- Children, young people and their families told us that staff were caring and supportive and we observed staff providing kind and compassionate care.
- The service received consistently high scores in the NHS Friends and Family Test.

Areas for improvement

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

Action the provider **MUST** take to improve:

- Ensure incidents are appropriately categorised, graded and investigated.
- Ensure that there are sufficient suitably qualified, skilled and experienced staff in the school nursing service to meet the needs of the local population.
- Ensure the policies and procedures for the management of the children's and young people's service are up-to-date, regularly reviewed, document controlled and readily accessible to staff.
- Ensure that a regular and effective clinical audit schedule is developed.
- Ensure that steps are taken to increase performance against waiting time targets for therapy services and the child development centre.
- Ensure that it improves the number of looked after children assessments carried out within the target timescale.
- Ensure children and young people's service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.

Action the provider **SHOULD** take to improve:

- Ensure that information available to parents and carers is available and accessible in languages other than English.
- Ensure that further work takes place to increase the telemedicine service offered.
- Ensure that staff are competent in assessing the mental capacity of parents and carers.
- Ensure that adolescents, parents and carers know where to access interim support when they are waiting a long time for appointments.
- Ensure that patient outcomes are effectively monitored.
- Ensure that learning from informal complaints is captured and shared with staff.
- Ensure that it develops its public and staff engagement capabilities.
- Ensure that it continues work to develop a vision and strategy for the service.

The Rotherham NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We carried out this inspection because when we inspected the service in February 2015, we rated safe as inadequate because children, young people and families were at increased risk of avoidable harm. We asked the provider to make improvements following that inspection.

At this inspection, we rated safe as requires improvement, because;

- Incidents were not always appropriately categorised or graded.
- Staff within the service had a limited understanding of the duty of candour.
- There was a risk that medical records were not contemporaneous.

- School nursing staff told us they were carrying high caseloads and that they had staff that had left since the time of our previous inspection. Our previous inspection also identified concerns about staffing and caseloads within the service.

However:

- The trust had made significant improvements to the medicines management and environment in the short break service.
- Safeguarding and mandatory training figures were generally above the trust target average.

Safety performance

- The service reported no never events or serious incidents in the past 12 months. Never events are serious incidents that are wholly preventable as

Are services safe?

guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Incident reporting, learning and improvement

- The trust used an electronic incident reporting system. Staff told us that this was easily accessible and that they were encouraged to report incidents. Staff received individual feedback on incidents they had reported the majority of the time. We saw that learning from incidents was discussed at team meetings and learning was shared via service newsletters.
- Between August 2015 and July 2016 community services for children, young people and families reported 117 incidents. The largest number of incidents (49) were reported by Health Visiting. The most common incident reports across the service was in relation to 'other' (21).
- We reviewed these incidents and saw that these included incidents that should have been recorded against a specific incident heading. These included reported concerns around safeguarding, information governance, and clinical incidents. This meant that there was a risk that incidents were not being accurately recorded by staff and that learning from trends and themes could be missed.
- We also identified a number of incidents graded as 'no harm' that involved harm. This included incidents in regard to unnecessary immunisation, patient falls, and significant information governance breaches. We could not see that the more serious incidents had been subject to any detailed investigation or root cause analysis process. This meant that there was a risk that the service was not ensuring it took learning from these incidents.
- Senior staff told us that all incidents were reviewed by the governance lead and discussed at senior leadership meetings. This provided an opportunity for significant incidents and themes to be identified and discussed. However, the data we saw suggested that this process did not result in incidents being recategorised or regraded. This meant that there was a risk that trends and themes from incidents were not being accurately reported.

Duty of Candour

- The trust had an up to date policy in place setting out the trust's approach to duty of candour. This also included wider 'being open' principles..
- Posters were displayed in staff areas to raise staff awareness of the duty of candour.
- Staff we spoke with had a limited understanding of the duty of candour. Staff were able to explain that this involved being 'open and honest' with patients. Management staff were also able to explain the formal process in place. However, other staff we spoke to were unable to explain the formal duty of candour process. Instead, a majority of staff understood that this was linked to the complaint process and was triggered by a complaint being made. This meant that there was a risk that the duty of candour would not be met within the service.

Safeguarding

- Data provided by the trust showed that nearly every staff group had achieved appropriate compliance with safeguarding children training. Modules were available at level two and level three, depending on the level of contact a staff group had with children. The target training rate was 80%.
- Data provided by the trust showed that only special school nursing services were not compliant with appropriate level three safeguarding training (60%). However, the service later told us that there was 100% compliance. Level two safeguarding was only required for a small number of staff within the service (16) and training compliance was at 75%.
- Nearly every staff group had met the target for appropriate safeguarding adults level two training. However, health visiting (61.5%) and speech and language therapy (75%) had failed to meet the target.
- Data provided by the trust showed that within the past 12 months there had been 138 safeguarding referrals made by health visiting or school nursing staff. In addition, another 431 referrals had been made by 'other' community services; however, it was not possible for the trust to specify where these referrals had been generated from. In addition, we reviewed the most recent five referrals to the multi-agency safeguarding hub. These were appropriately completed.
- Staff we spoke to were aware of how to contact safeguarding leads for the service and reported no concerns in accessing appropriate advice and guidance.

Are services safe?

- The trust did have a policy in place to set out the steps staff should take if children and young people failed to attend for planned appointments. This made appropriate reference to national guidance and identified the safeguarding concerns that could arise from missed appointments.
- However, staff we spoke with had a limited understanding of the safeguarding concerns arising from children and young people failing to attend appointments. The staff we spoke with did not provide us with a consistent approach to how such situations were handled to ensure any safeguarding issues were identified.

Medicines

- During our last inspection we identified concerns around how medicines were managed within the short break service. This was due to medicines being pre-prepared by parents prior to children attending the service and how these medications were subsequently labelled and stored. Following the previous inspection, staff told us that there was a now a long term strategy in place to improve medication provision.
- At the time of our inspection, we observed that parents drew up medication under observation from staff. Medication was then labelled with name, patient name, dose, strength, time of administration and was stored in a locked cupboard or fridge until it was required.
- We saw that medicines within the immunisation team were stored securely and at appropriate temperatures. We observed immunisations being transported to a school. This was done in portable fridges to maintain the 'cold chain'. A cold chain is a temperature-controlled supply chain. An unbroken cold chain is an uninterrupted series of storage and distribution activities which maintain a given temperature range. This ensured that medicines remained stored at the correct temperature to maintain their effectiveness.
- Relevant staff had up to date patient group directives in place to allow them to administer vaccines and medication. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor.

Environment and equipment

- The trust held a central electronic register listing equipment and maintenance schedules. This identified equipment held in the community and the timescales for testing and maintenance.
- We checked five pieces of equipment. These were all in date and had been appropriately maintained.
- During our previous inspection staff told us that their laptop computers were outdated, unreliable, and led to problems connecting to the trust system and storing work. We noted that new laptops had now been made available to the majority of the staff we spoke with, with other staff noting that laptops were on order or due to be provided in the near future.
- Staff told us that the mobile phones they were provided with were now outdated and had reception and connection issues. Management staff told us that they were shortly due to order new telephones for staff to help resolve this issue. Staff were aware that new phones were due to be provided.
- The short break service explained that children attended with their own medical equipment as required. In advance of a child attending, staff agreed with carers what equipment was required. The equipment was checked on arrival to ensure it was safe. If no equipment was brought, staff told us that they would not provide care until the equipment was brought from home.
- Clinic environments we visited were clean and we saw that appropriate cleaning schedules were in place.
- Many of the services we visited were co-located in modern multi-service buildings. These offered appropriate office and clinical space where required.

Quality of records

- The service had carried out an audit of its electronic records. The audit considered 50 records made between November and December 2015. This identified varying compliance with good record keeping practices. For example, 100% of records had the correct information sharing privileges set and 90% of records contained a summary of the care provided. However, 10% of records were not completed within 24 hours of patient contact, 24% of records did not fully record the voice of the child, and 50% of records did not record the full name or details of persons referenced within the records.

Are services safe?

- As a result of the audit, the service had identified that it would 'explore ways to improve record keeping'. We saw that a formal action plan was in place to improve record keeping and that the actions it identified had concluded shortly before our inspection.
- The service carried out an audit of looked after children health assessment records. This identified 95% compliance with the record keeping and assessment standards expected by the trust.
- We reviewed 20 patient records during our inspection visit. These contained appropriate patient information and were in line with professional standards.
- There was a risk that the information contained within the records was not contemporaneous. Staff told us that they had received laptops to assist in agile working. Laptops were used in clinic locations; however, the majority of staff we spoke with told us that they did not use laptops in patient homes or take them on visits. Instead, staff either recorded notes on paper or told us that they would try to remember details of their visits. There were then inputted into the electronic record when staff returned to their base. At the time of our visit, management staff told us that the service was working on an agile working policy to provide further guidance to staff.
- The health informatics team told us that records from other providers, and from other trust services such as the emergency department, were received into the team to be scanned onto the service's electronic record system. Staff told us that there could be delays in scanning being placed on the system due to the volume of documents received and a lack of capacity. This meant that there was a risk that information could not always be uploaded to patient records in a timely way.
- At the time of this inspection, the service had a washer, dryer and dishwasher on site. We reviewed a number of cleaning records for specific areas that documented what cleaning was required and that it had been carried out. These were then counter-signed by a manager. These records showed that cleaning took place at the beginning, end and throughout the day. Staff had worked closely with infection control team to ensure service was compliant. A deep clean of the area was booked where the service would be closed to enable cleaning of ceilings, for example.
- Each child in the service had a place mat where their food/ drinks were stored to reduce cross contamination between children. All play surfaces were wipe clean. Carpets were cleaned regularly and were visibly clean during the inspection
- Details from the latest (June 2016) audit of microbial decontamination and bare below the elbow policy showed 100% compliance in the six areas assessed across health visiting and school nursing.

Mandatory training

- The Trust set a target for 80% of staff to be compliant with its core mandatory and statutory training (MAST) modules.
- Data provided by the Trust showed that the majority of staff groups within the service had achieved 80% or more compliance with MAST training. The only exception to this was the breast buddies service, which had achieved 78.6%.
- Staff told us that training was accessible via the intranet and also via face to face sessions.
- We saw that service managers kept logs of staff training and staff confirmed that they received reminders from managers and via the electronic system to confirm when MAST training was due to be completed.

Assessing and responding to patient risk

- The service had carried out an audit of its electronic records. The audit considered 50 records made between November and December 2015. This identified that 42% of records contained only a partial or no assessment of risk. We did not see any evidence of a formal action plan in place to address this concern. This meant that there was a risk that staff within the service were failing to consider and record risks to children and young people.

Cleanliness, infection control and hygiene

- The service was achieving a training rate of 82% for infection, prevention and control training. This was better than the trust target of 80%.
- During our previous inspection we noted concerns around cleanliness and infection control procedures within the short break service. This was due to a lack of formal infection prevention and control guidance and cleaning schedules in place. There were also concerns that a lack of washing and drying facilities on site meant that washable items were not always cleaned appropriately, or were being taken home by staff for cleaning.

Are services safe?

- However, staff we spoke with were able to recognise and respond appropriately to a deterioration in a child's health. Staff explained how this would be escalated to seek support from colleagues and when it would be appropriate to contact emergency assistance.
- Staff we spoke with were aware of how to escalate concerns about the health of children and young people. The majority of clinics were provided in community locations and home visits also took place. Given this, staff explained that they would call for an emergency ambulance or via NHS 111 as appropriate if they had concerns about the health of a child or young person.

Staffing levels and caseload

- Current staffing for the health visitor service in August 2016 was 62.5 whole time equivalent (WTE) qualified staff. This was in line with planned staffing levels. At the time of the inspection, there were 4.0 WTE on maternity leave and 2.2 WTE absences due to long term sickness.
- Qualified health visitors carried a caseload of approximately 280 children. These were weighted according to health needs. Staff in the service told us that they were very busy and sometimes struggled to manage the caseload they received. However, the size of caseload was in line with wider Royal College of Nursing guidance on caseload size.
- Current staffing levels for school nurses at the time of our inspection was 16.3 WTE against a planned staffing level of 16.7 WTE. This figure did not include special school nursing staff. This service was fully staffed at 3.9 WTE.
- Schools nursing caseloads equated to approximately 3150 children per school nurse. These were reviewed corporately. In addition, there was a named school nurse for each secondary school and primary school cluster.
- In our previous inspection, we identified concerns around caseloads being carried by school nurses and the feedback they provided around demands on their time. In particular, staff raised concerns that safeguarding caseloads were unmanageable and took away from them being able to carry out other patient contacts. We said that the trust must ensure that there are sufficient suitably qualified, skilled and experienced staff in the school nursing service to meet the needs of the local population.
- The majority of school nurses we spoke with told us that they were still 'stretched to the limit'. Many staff told us that they were looking after two secondary schools and the associated primary schools. This was not in line with Royal College of Nursing staffing guidance.
- In addition, we saw that school nursing staff were carrying high numbers of safeguarding cases (877 children with a child protection plan, 2156 children in need, and 217 looked after children). Staff explained that they had begun working with colleagues in health visiting to share safeguarding caseloads for families where there were below school age children in the household.
- Staff told us that colleagues had left the service and had not been replaced. This was reflected in planned staffing numbers we received from the trust. For example, a report in April 2016 identified a WTE of 21.6 nurses with a further nurse planned to start within the service. This was not reflected in the staffing figures we received at the time of our inspection.
- Management staff told us that consideration around staffing was set out in the 0-19 tender that had recently been won by the service and that the intention would be to increase the skill levels of all staff within the 0-19 service to provide greater staffing flexibility. However, we were told that this could take two to three years to complete. We were not told that school nursing staffing would increase in the interim or that any plans were in place to address current workload concerns.
- The school nursing service had employed a specific immunisation team in order to deliver the immunisation programme. Senior staff told us that this would reduce the day to day workload of school nursing staff. However, this team had been taken from the existing school nursing staffing establishment and was not an additional resource within the wider service.
- Therapy services and the Child Development Centre were meeting planned staffing levels. There was an identified shortage of qualified and unqualified staff within the community nursing service of 1.4 WTE qualified staff and 7.6 WTE unqualified staff.
- The service told us that there were 2.9 WTE medical staff dedicated to community work. At the time of the inspection, there was an additional one WTE community medical consultant post agreed that was out to recruitment. There were also two WTE community registrar posts, however these staff were employed via another NHS trust.

Are services safe?

- Sickness rates throughout the service were routinely above the Trust target of 3.5%. On average, the sickness rate was 5%.

Managing anticipated risks

- The service had a lone working policy in place. Staff we spoke with explained that they would be able to identify visits that may require more than one staff member due to increased risk via the electronic system. Staff also told us that they would 'check in and check out' of bases to ensure that colleagues knew where they were due to be, and when they had left visits.
- We saw appropriate policies in place for services to provide guidance on what to do in the event of adverse weather. These included relevant escalation plans and activity prioritisation to determine how vital services would continue to run.
- We saw that 'grab bags' were available in staff bases. These included policies, standard clinical documentation templates and contact lists to ensure business continuity.

Are services effective?

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

Summary

We carried out this inspection because when we inspected the service in February 2015, we rated effective as requires improvement because children, young people, and families were at risk of not receiving effective care or treatment. We asked the provider to make improvements following that inspection.

At this inspection, we rated effective as requires improvement, because:

- The service was failing to meet performance targets in regard to the national healthy child programme. This had been highlighted at our previous inspection.
- There were limited examples of regular or robust audit or outcome monitoring in place to ensure that the service was assured it was providing effective care and treatment. This had been highlighted at our previous inspection.
- There was very limited use of telemedicine or technology to help in delivering effective care.
- There were inconsistencies in how staff accessed clinical supervision and this was not always in line with the trust policy.

However:

- The trust had significantly improved the percentage of staff undergoing a formal appraisal.
- We saw evidence that staff were receiving clinical and safeguarding supervision..
- There was effective multidisciplinary working amongst different teams within the service and wider health and social care services.

Evidence based care and treatment

- The service had recently completed audits of electronic health records, care plans for looked after children, and nurse practitioner clinics at the child development centre. We saw that some actions had been identified to address the findings of the audits. However, we did not see that robust action planning was in place to ensure that actions required were clearly identified, monitored and assessed to ensure effectiveness.

- At the time of our inspection, specific audits of safeguarding practice were taking place for electronic record, 'safe sleep', care plans for looked after children, and 'leavers journeys' for looked after children. The results of these audits were not available to us at the time of our inspection.
- However, there was no regular or formal audit plan in place for the service. Management staff told us that audits were chosen for the year in advance through consultation with wider trust leadership. The subject of the audits would change year to year; unless follow up audits were required. This meant that there was no formal, regular overview to determine if services were following evidence based practice.
- We saw that policies and operating procedures in use within the service made appropriate reference to national and professional guidance issued via the National Institute for Health and Care Excellence and royal colleges.
- The trust had UNICEF level three baby friendly accreditation and was able to offer support and guidance on breast feeding to new mothers.

Technology and telemedicine

- The service acknowledged that there was very limited use of technology or telemedicine at the time of our inspection. There was no use of social media, internet or assistive technology in the majority of services we visited.
- The tender submitted for the new 0-19 pathway did include provision for an increased use of technology and telemedicine. However, this was in a very early stage of planning and development.
- The diabetes service did use a remote system whereby patient blood results were uploaded to an online system.

Patient outcomes

- The health visiting service was failing to meet a number of performance targets as at August 2016. This included antenatal contacts (80.1% vs a target of 100%); new

Are services effective?

birth visits (90.1% vs a target of 95%); percentage of infants being breastfed at six to eight weeks (30.35% vs a target of 33.5%); two to two and a half year child reviews (83.4% vs a target of 100%).

- The school nursing service was also failing to meet some core performance targets. As at August 2016, the service was failing to meet targets for the number of children reviewed with an identified health need (78.9% for the financial year to date vs a target of 90%) and the meningitis C (74.3% vs a target of 85%) and DTP vaccination target (68.5% vs a target of 85%).
- There was limited use of other tools to collect outcome data to evidence that effective clinical care was provided. The majority of staff we spoke with referred to friends and family test data as being the only way in which patient outcomes were recorded.

Competent staff

- Data provided by the trust showed that an average of 81.7% of staff had an up to date appraisal at the time of our inspection. Seven staff groups had attained 100%. This average percentage had increased significantly from 2013/2014 when it was estimated that approximately 11.9% had undergone an appraisal.
- Staff we spoke with told us that they found the appraisal process useful and could input into decision about their developmental needs.
- The trust had an up to date policy in place setting out the requirements for staff to undergo clinical/practice supervision. This set out that the supervision should be formally recorded and should take place once per year as a minimum requirement.
- The trust had an up to date policy in place to provide for safeguarding supervision for staff. This set out that safeguarding supervision should take place a minimum once every three months (four times per year) with each session lasting approximately two hours.
- There was some inconsistency in regard to how staff undertook supervision. Some reported that this was informal, some reported one to one supervision in line with the trust policies, and some reported a 'case' based approach where clinical and safeguarding supervision took place at the same time as part of a review of a practitioners caseload. This was listed under a specific module on the electronic records to allow data on supervision to be collated. This meant that there was a

risk that there was not a consistent approach to how supervision was offered or reported. The service told us that there were plans to address this with the adoption of a new supervision model from January 2017.

Multi-disciplinary working and coordinated care pathways

- We observed positive interactions between multidisciplinary staff located within the multi-specialty locations. These were joint care centres where health and social care were provided and separate teams were based. Staff told us that this meant that they could easily access and speak with colleagues from other health or social care specialties in order to discuss patient needs and raise informal queries.
- Physiotherapy and occupational therapy staff reported good relations with other specialties within the service. They explained that referral to therapy services was routinely part of discharge packages.
- Our previous inspection had identified that there was a lack of liaison between school nursing and sexual health services in regard to children and young people who were attending both services. At the time of our inspection, we saw that a standard operating procedure was now in place setting out a standard, risk based communication pathway between these services and wider social care. This provided assurance that appropriate communication was being facilitated between these services.
- The school nursing and health visiting service had moved to a duty system. This meant that one member of staff was available to take calls in every team. Staff in the health informatics team told us that this had been helpful in ensuring they could speak to team members quickly. However, staff within the school nursing and health visiting service described this as an extra pressure; taking a member of staff away from clinical duties.

Referral, transfer, discharge and transition

- Staff within the health visiting and school nursing service described how children transitioned between these services. Standard information forms were completed for the majority of children. However, children with specific needs or at increased risk were discussed at face to face meetings to ensure their care was handed over appropriately.

Are services effective?

- Staff within the school nursing service reported some problems in having referrals to mental health services accepted. However, we were told that good links existed with mental health services and a duty worker was available to provide support and advice on referrals and wider care issues.
- School nursing and health visiting services could directly refer into other community based services, such as physiotherapy and dietician support.
- Parents were also able to self-refer to speech and language therapy. Referrals were then triaged and support was offered via group or 1:1 sessions.

Access to information

- Staff within the service had access to an electronic record management system. We saw that staff were able to access the system and view relevant patient information for patients attending community services. The trust used different record systems for some inpatient services and sexual health services. This meant that community based staff could not access all the relevant patient information via their computer system.

- Staff were able to use the trust intranet to access guidance and policies. We observed staff accessing policies online.
- Staff reported that connectivity issues could still occur in some areas. Where this was an issue, staff were unable to access the online systems. Staff told us that they knew the areas where connectivity was a problem and would take steps to prepare for visits/clinics in these areas by pre-reviewing patient information or relevant policies online.

Consent

- We saw that there was a consent policy in place and staff we spoke with were confident in taking consent from children and young people. Staff were able to make reference to the use of Gillick/Fraser competencies in assessing whether a young person was able to consent to their treatment.
- We saw that appropriate discussions around consent were noted in the records which we reviewed.

Are services caring?

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

Summary

At our previous inspection we rated caring as good because children, young people and families were treated with compassion, kindness, dignity and respect. Following this inspection we also rated caring as good, because:

- Children, young people and their families told us that staff were caring and supportive and we observed staff providing kind and compassionate care.
- Staff involved children, young people, and their families in care planning and provided tailored advice and guidance to ensure clinical needs were understood.
- The service received consistently high scores in the NHS Friends and Family Test.
- Staff treated children, young people, and their families with dignity and respect.

However:

- Parents of children waiting to access services were unsure how to access emotional support and told us they felt they 'slipped between the cracks'.

Compassionate care

- Community services for children, young people and families performed consistently well in the NHS Friends and Family test. The latest available results at the time of the inspection were for June 2016. This showed that 99% of children, young people, or their families would recommend the service to others. This is compared to a national average of 95%.
- We observed care being delivered in clinic settings, in schools, and in children's homes. We saw that staff delivered care in a compassionate and caring manner.
- We saw that staff treated children, young people, and their families with dignity and respect.
- Children, young people, and their families that we spoke to described staff as being good and said that the staff they encountered had all been caring and supportive.
- Staff in the short break service told us that older children who had left the service were invited back during school holidays. Where a child was in hospital, staff would contact parents to offer support. Parents would be contacted routinely to offer support and places at the centre in vacancies came up.

Understanding and involvement of patients and those close to them

- We observed school children undergoing vaccinations being provided with information on the vaccine they were to receive and the process of vaccination.
- Parents of children using the short break service told us that they were highly involved in decision making around the service and improvements that were being made. Parents told us that they were contacted when their child was in hospital and that they would be contacted to confirm when support or appointments were available.
- We observed staff providing parents and adolescents with evidenced based information on healthcare needs. This included relevant information on child development being provided by health visiting staff. Staff then asked parents to repeat this information to confirm it had been understood. We also observed staff discussing care plans with parents and seeking their input and agreement before agreeing what care was to be provided.

Emotional support

- Parents, children, and young people we spoke with told us that they felt supported by staff and would be confident in seeking support for any concerns.
- We observed staff adapting their practice to meet the emotional needs of patients. An example of this included the immunisation team allowing nervous patients in a school setting to see them first, and on their own. They were then able to provide extra support and information to support the young people undergoing immunisation.
- One member of staff told us how they were engaging with a parent and child who were at high risk of domestic violence, offering support and referring to appropriate services where available. Staff also told us of occasions when they had arranged care at short notice whilst parents/other siblings had appointments.
- Staff in the family nurse partnership and early attachment service were able to offer emotional support to women in pregnancy and with young children.

Are services caring?

- Two parents described problems accessing speech and language therapy services due to the waiting times they

encountered. Although they felt that staff were supportive when they saw them, they described 'slipping through the cracks' and not knowing where to seek support during the waiting period.

Are services responsive to people's needs?

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

Summary

We carried out this inspection because when we inspected the service in February 2015, we rated responsive as requires improvement because the needs of children, young people, and families were not always met. We asked the provider to make improvements following that inspection.

At this inspection, we also rated responsive as requires improvement, because:

- Some services were not meeting referral to treatment target times for initial appointments. This had been highlighted at our previous inspection.
- There were long waits for treatment following first appointments in speech and language therapy. This had been highlighted at our previous inspection.
- The service was not meeting the needs of looked after children and there were delays in child protection information being available to staff.
- Patient information was not routinely provided in a range of languages. There was a risk that instructions on how to access information in other languages would not be understood by young people and families that did not speak English as their first language. This had been highlighted at our previous inspection.
- The trust did not routinely share learning from informal concerns. This had been highlighted at our previous inspection.

However:

- The trust had taken steps to ensure that access to child and adolescent sexual health services were available to young people outside of school term times.
- Services were planned to meet the needs of children, young people, and families.
- We saw learning from formal complaints was shared with staff.

Planning and delivering services which meet people's needs

- During our previous inspection we noted that there was an early attachment service available. Health visitors could refer families where there were concerns around bonding between mother and baby. However, we found

that the service was not viable as it relied on a single health visitor to operate. During our inspection we saw that an additional staff member was now in place to ensure that there was a more viable service available.

- Our previous inspection had identified concerns around access to child and adolescent sexual health services in the school holiday period. This was because many of the clinics did not operate in holiday period. We found that extra clinics were now open during school holidays; including one in Maltby and one in Rotherham town centre. This improved access to these services for children and young people in holiday periods.
- Many services were provided at multiservice centres. These often incorporated health and social care staff, as well as GP practices. Some centres we visited also contained leisure facilities, such as libraries and sports centres. Patients we spoke with told us that this was convenient and allowed them to access multiple agencies at a single centre.
- Clinics also operated from a variety of local health centres at specific days every week. This ensured that patients could access services across the Rotherham area if they were unable to travel to some central sites.
- The service had developed a new 'alcohol' pathway for adolescents. A liaison nurse worked with staff in the trust's emergency department to identify alcohol related admissions. They then provided guidance to adolescents and their families and could make appropriate referrals to drug and alcohol services provided by a local NHS trust.
- Parents told us that information leaflets were available to help them understand the care and treatment being provided to their children. We saw that there were limited examples of leaflets being available in clinical settings that were written for children.
- The Trust confirmed that there had been no commissioning for quality and improvement (CQUIN) targets or other targets set on its service by commissioners. This was as a result of service specifications being out of date; not having been updated with the local clinical commissioning group

Are services responsive to people's needs?

since 2009. The trust said that it was engaging with the local clinical commissioning group to try and ensure its targets were updated and reflective of the current demand on services

Equality and diversity

- Spoken translation services were available via both telephone and face to face translation services. Document translation was also available. Staff told us that interpreter bookings could be made either by telephone or online 24 hours/day.
- The service reported that the current fulfilment rate for interpretation service requests was 99%. Staff within the school nursing service told us that they had good links with school based interpreters who could also provide assistance.
- The service did not routinely produce patient information leaflets in different languages. The service identified that all leaflets produced by the service now included information on how to access leaflets in another language, large print, braille or easy read. The leaflets we saw on display were written in English and in standard type set. This meant that there was a risk that children, young people, or their families may not be able to understand information provided to them. This was also highlighted at our previous inspection.
- However, the service told us that all new leaflets did have information in a number of languages advising that leaflets can be made available in alternative languages if required.
- We saw that guidance was available to staff on how to access translation or easy read leaflets via external websites or contacting the trust's translation services.

Meeting the needs of people in vulnerable circumstances

- The service carried out an audit of the time taken for child protection medical documentation to be added to the permanent medical record. The target was for 100% to be placed on the record within 5 working days. The audit identified that there was a delay in placing 20% of the reports on the electronic record due to the commitments of medical staff in completing and reporting the medicals. No actions had been identified to improve this performance.
- The short break service offered six hour sessions from 10.00am to 4.00pm, five days a week. The complex care team was able to provide care at home over night.

- The child and adolescent sexual health service held outreach clinics to target harder to reach groups, such as: university students, homeless groups, and women's groups, and vulnerable people. Staff explained that they had the ability to carry out testing and education outside of the clinic environment.
- The service employed a youth offending nurse. They were based within a multi-agency partnership team with the aim of preventing offending and re-offending. The nurse ensured that health needs were determined and that young people were signposted to the correct services for their health needs.
- The service employed two health visiting staff to work specifically with the migrant community. This allowed the specific needs of this community to be addressed.

Access to the right care at the right time

- The child development centre had a target to complete 90% of initial health assessments within six weeks. At the time of our inspection, the service was achieving approximately 65% of children being seen within this period.
- There was then an average wait of approximately 11 months before children were seen for further assessment of any autistic spectrum disorder. This was against NICE guidance stating that children should be seen within a nine month period following initial assessment. The child development centre explained that there were insufficient new paediatrician appointments to keep the service timescales within the NICE guidelines for Autism spectrum disorders. There was a pilot in place utilising a nurse post to provide follow up clinics and additional medical staffing was out to recruitment.
- The looked after children service had a target to carry out health assessment within 20 days of referrals being made. At the time there was 0% compliance with this target. Staff told us that delays in referral from social care were impacting on the target. The service was working with the local council to address this issue.
- The speech and language therapy team had a target to see patients for an initial assessment within 8 weeks. At the time of our inspection, the average waiting time was reported to be approximately 4 weeks for new patients.

Are services responsive to people's needs?

- Following initial assessment, there was then an average wait of between 10-12 weeks for routine treatment. The service told us that they had recruited new staff to post and it was hoped that this would allow waiting times following assessment to reduce.
- The physiotherapy service was meeting its target for initial assessments to be offered to patients within four weeks of referral. However, a minority of patients were reported to be waiting for six weeks for treatment.
- The occupational therapy service was also meeting its target for initial assessments to take place within 18 weeks of referral.

Learning from complaints and concerns

- The service reported that it had received four complaints within the 12 months prior to our inspection. These complaints related to community therapy, physiotherapy, school nursing, and the child development centre. Two complaints were recorded as not upheld, one was partly upheld, and one was listed as 'N/A'.
- Whilst on site we saw logs showing that a larger number of complaints had been received (approximately 12). We raised this with the leadership team who told us that these were informal complaints. We were told that 'informal' complaints would include complaint that involved a recorded resolution meeting. This was not in line with the trust complaint policy. Such meetings would often be classed as being part of a formal complaint process. However, this did not impact on complainants receiving a response to their concerns.
- We saw that learning from complaints was shared via newsletters and feedback in staff meetings. However, feedback from informal complaints was not logged or shared. Due to the way in which the trust categorised informal and formal complaints, this meant that there was a lost opportunity for the trust to learn from all the informal concerns it received.
- We reviewed the last three complaints received into the service. Responses were provided in a timely manner and contained appropriate explanations of care provided. Where failings were identified appropriate apologies and actions to improve services were included.

Are services well-led?

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

Summary

We carried out this inspection because when we inspected the service in February 2015, we rated well-led as requires improvement because the leadership, governance and culture did not always support the delivery of high quality care for children, young people and families. We asked the provider to make improvements following that inspection.

At this inspection, we also rated well-led as requires improvement, because:

- The service had not yet developed a clear vision or strategy to reflect how services would be provided across the local area.
- The risk register was not always regularly updated or maintained and did not contain evidence that mitigating actions were regularly monitored.
- Staff in the 0-19 pathway told us that they did not feel that feedback was valued or acted on in regard to the 0-19 tender process.
- There was a lack of formal public or staff engagement in order to drive improvements and make changes to services outside of the 0-19 pathway tender.

However:

- Staff told us that there had been positive improvements in the culture within the service since our last inspection.
- Regular team and service level meetings took place to allow governance issues to be discussed.
- Staff spoke positively about the support provided by their teams and immediate management.

Leadership of this service

- The leadership team for the service included a head of midwifery, services and professions, a clinical director and a general manager. There was a deputy head of nursing in place, with the post of deputy clinical director vacant at the time of our inspection. Matrons and service managers were then responsible for the individual services.

- The leadership team all spoke positively of the support available within the leadership group and told us that they worked collaboratively and effectively in order to try and drive improvements to services.
- The acute and community children and young person's service had taken part in a trust wide staff survey in September 2015. It was not possible for the trust to provide data to show community responses alone. Questions in which the service performed worse than the trust average included questions in relation to effectiveness of immediate and senior management staff.
- Staff we spoke to were positive about their immediate line management. Staff reported feeling well supported and able to discuss concerns with their managers.

Service vision and strategy

- We saw posters on display in clinical and staff areas which displayed the trust strategy and goals. However, we did not see any literature that referred specifically to a vision or strategy for the children's and young people's service.
- Management staff explained that the vision and strategy for the service was in development and that the service was still at the early stages of its transformation programme. Staff told us that they understood the wider trust vision and strategy, but that a service specific vision and strategy was in development.
- Management staff told us that the vision for the 0-19 pathway was set out in tender documentation and set out a range of options for the future provision of services. This included an increased staff presence in community locations and staff skills mix considerations.
- The child and adolescent sexual health services was currently in the process of merging with adult genitourinary medicine services. Management staff told us that consultations were ongoing and the vision and strategy for the service was in development.

Governance, risk management and quality measurement

- The service had a risk register in place. This identified a total of sixteen risks, of which one was rated as high and

Are services well-led?

one was rated as severe. Management staff told us the risk register was discussed at the monthly governance meetings and that any high scoring risks would be escalated to the patient safety and risk team.

- We reviewed the risk register and saw that there was a lack of consistent oversight or management of the risks on the register. For example, some risks had not been updated for more than six months; some review dates fell over 12 months from the last update on the register; and some historic risks remained on the register when action was complete. This meant that there was a risk that identified risks were not effectively reviewed to ensure that appropriate mitigating actions were in place.
- The high risk related to children who were identified with possible abuse risk factors by the CASH service not being identified to the school nursing service. The risk register noted that as of November 2015 records had been shared between the services to mitigate this risk. This was next due to be reviewed in October 2016, but no interim action was identified to review the effectiveness of measures in place.
- The severe risk related to the service being unable to complete tenders to bid to provide services. The risk had been added in September 2015. There had been no update as to what mitigating actions had been taken and the next identified review was in February 2017.
- A risk in relation to staffing levels in the School Nursing service had been added to the risk register in October 2015. This was identified as moderate risk. We saw that there had been no update to the register to reflect any ongoing mitigation action at the time of our inspection.
- We reviewed minutes of team meetings that took place within the specialties. This included minutes provided by the child development centre, speech and language therapy and 0-19 services. We saw that meetings provided an opportunity for incidents, guidance and practice issues to be discussed.
- We reviewed minutes of the last three children and young people's governance group meetings. This included multi-disciplinary representation from across the service. These included discussions around patient safety, incidents, patient experience and updating guidance.
- Management staff for children's services provided information about document control policies and procedures for trust policies. They described that 87% of documents (approximately 200) across the wider

children' service had been out of date 18 months ago. They said the position had improved, with 55% of documents still requiring update and review. A plan was in place to complete this work by the end of 2016. This meant that there was a risk that policies and procedures were not up to date with relevant guidance.

Culture within this service

- The acute and community children and young person's service had taken part in a trust wide staff survey in September 2015. It was not possible for the trust to provide data to show community responses alone. Of 86 questions, services for children and young people performed worse than the trust average scores for 32 questions, better than the trust average for five questions, and in line with trust averages for the remainder.
- Questions in which the service scored below average included questions in regard to how valued staff felt in their role, whether they were able to and trusted to use their skills, and how frequently they had experienced harassment or bullying.
- Staff told us they felt there was an open culture within the service. They said that there had been an improvement in the culture in the last 18 months. Staff provided examples of increased visibility or senior leaders and better communications. They said all grades of staff were friendly and approachable.
- The majority of staff we spoke with described their teams as very supportive and felt that there was a culture of 'putting the patient first' within the service.
- Staff we spoke with in the 0-19 service were less positive about the culture within the service. They also reflected that the culture had improved, but told us that they did not feel that they were always listened to when they raised concerns about the provision of the service.

Public engagement

- The service used the NHS Friends and Family test to gather feedback from patients. The service told us that no other specific trust or service based patient surveys were routinely used to gather feedback.
- The school nursing service had attended a local youth forum that discussed adolescent mental health services. Staff had a stall and passed out information leaflets on school nursing services. They were also available to provide advice and guidance to any young people that approached them with concerns.

Are services well-led?

Staff engagement

- The acute and community children and young person's service had taken part in a trust wide staff survey in September 2015. It was not possible for the trust to provide data to show community responses alone. Questions in which the service performed worse than the trust average included questions in relation to whether staff were engaged in decision making by leaders and whether leaders acted on staff feedback.
 - All paediatric therapists were invited to respond to a survey asking what works well in their services and what could be improved. The trust received six completed responses, which identified concerns about resourcing, staffing, waiting lists and a lack of clarity about senior management structures.
 - The trust policy on peer support also set out that Schwarz rounds could be used by the clinical team. These are meetings for staff to come together to explore the emotional and psychological impact of their work. These were voluntary and the hospital explained that these were provided via drop in sessions, with the last being in September 2016.
- A regular newsletter was circulated to staff within the wider children and young people's service. This provided staff with information on current developments, learning, and highlighted feedback and compliments about the service.
 - Staff told us that they had been engaged by senior leaders in discussions around the 0-19 tender process. Staff did say that they had been kept up to date with progress around the tender and had received relevant information about the new care models being proposed. However, the majority of staff felt that this engagement was limited and superficial. Staff described not feeling able to influence decisions and that they felt decisions had already been made prior to any input being requested.

Innovation, improvement and sustainability

- The services were working with the local authority and the local clinical commissioning group to develop a clinical portal. This was intended to provide a single health and social care records for children and young people on protection plans. This was in development at the time of our inspection.

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 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

How the regulation was not being met:

The risk register was not always regularly updated or maintained and did not contain evidence that mitigating actions were regularly monitored.

Incident grading and investigation was not always appropriate

There was a lack of robust audit and patient outcome monitoring.

Waiting times for services were excessive and we saw limited evidence of pro-active measures being taken to tackle waiting list issues.

Policies and procedures for the management of the children's and young people's service are up-to-date, regularly reviewed.

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014

Staffing

How the regulation was not being met:

There were insufficient numbers of suitably qualified, competent, skilled and experienced school nurses.