Suffolk County Council

1-101616919

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-224818188	Endeavour House		

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

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Overall summary

We did not rate the service. We found:

- Safety performance over time was good, the quality of healthcare records was high, equipment was serviced appropriately and environments were safe and suitable for purpose.
- Despite low staffing numbers in some areas of the service provision, with planned future budget cuts, senior managers were taking appropriate action to sustain services. Staff we spoke too stated that despite some staffing level concerns they felt they were able to provide safe care.
- Service users had their needs thoroughly assessed, care goals identified and care plans were in place accordingly.
- Breastfeeding rates were above target and improving overtime and blood spot screening for eligible babies was 100%.
- Staff were competent and access to additional training was very good.
- We saw evidence of effective multidisciplinary (MDT) working and collaborative pathways for service users.
- We observed staff treat people who used the service with dignity, respect and compassion.
- Services were planned and delivered which met the needs of local people, including those with different needs and in vulnerable circumstances.
- People could access the service in a timely way and there were examples of innovation in terms of a text messaging system used for school aged children.
- Complaints were low and handled effectively.
- Staff spoke highly of their seniors stating that they were visible, approachable and supportive, and described a culture within the service whereby the child was paramount, a culture of candour and working together.
- Service users and staff had opportunity to engage with the service on varying levels, and there were numerous examples of innovation, improvement and sustainability to service provision.

However there were also a number of concerns relating to the safety, effectiveness and governance of the service that needed to be addressed. We found:

- A lack of staff training and policy relating to the duty of candour.
- Insufficient formal arrangements were in place for the ordering and supply of medicines.
- The majority of service documents we reviewed, including policies and patient leaflets, did not contain either date of issue or a review date, and not all staff were able to access the service's new policy and procedure database.
- Some of the Health Child Programme (HCP) outcomes were not being met due to a lack of staff.
- Performance data for the school nursing service was insufficiently captured and monitored.
- Some data was missing from employment records such as the date when pre-employment checks were carried out.

Summary of findings

Background to the service

Suffolk County Council provided a range of health services for children and young people aged 0-19 years, and their families. This was both universal and targeted community based healthcare and services included: health visiting, school nursing, special school nursing, named nursing for safeguarding children, children in care nursing, community learning disability nursing, enuresis and family nurse partnership services. These services were delivered from a range of community settings including health centres, children's centres, schools and service user's homes.

The service operated from Endeavour House in Suffolk and services were available to all children, young people and their families living in the county of Suffolk, with exception to people living in the Waveney region whereby another provider operated.

Overall the service employed 30 senior, service and team managers, 200 registered nurses, health visitors and school nurses, 78 family support practitioners, children's health advisors and behavioural support assistants, and 78 business support assistants.

The service budget for 2016 to 2017 was £9.2 million pounds.

The service first registered with the Care Quality Commission (CQC) in March 2011 to provide the following regulated activities:

- Nursing care
- Treatment of disease, disorder or injury

There was a Registered Manager for the service who had been in post since November 2014.

Demographic data about the Suffolk region:

- 7,960 live births in 2014
- 22.6% of the population in Suffolk were children and young people
- 13.2% of school children were from a minority ethnic group
- The health and wellbeing of children in Suffolk was generally better than the England average
- Infant and child mortality rates were similar to the England average
- The level of child poverty was better than the England average
- The rate of family homelessness was better than the England average
- Life expectancy was better than the England average

(Public Health England, 2016).

During our inspection we spoke with 39 members of staff including health visitors, school nurses, support staff, specialist nurses, the registered manager and other managers and senior managers. We visited two child health clinics where we spoke with six people who had used the service and we reviewed the healthcare records of 20 service users. We examined a number of documents the service had sent us including some of their policy and procedures and audit results. We also contacted stakeholders who worked with the service, such as other healthcare providers, and asked for feedback from them about the service.

Our inspection team consisted of two CQC Inspectors, one of which had a background in health visiting.

Our inspection team

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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

Before visiting, we reviewed a range of information we hold about the core service. We carried out an announced visit on 07 March 2017 and an unannounced visit on 20 March 2017. To get to the heart of people who use services, 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?

During our inspection we spoke with 39 members of staff including health visitors, school nurses, support staff, specialist nurses, the registered manager and other managers and senior managers. We visited two child health clinics where we spoke with six people who had used the service and we reviewed the healthcare records of 20 service users. We examined a number of documents the service had sent us including some of their policy and procedures and audit results. We also contacted stakeholders who worked with the service, such as other healthcare providers, and asked for feedback from them about the service.

What people who use the provider say

People who used the service told us that staff were "very supportive "and "are always friendly and welcome you here". People also told us that they felt involved in and understood their own and their child's care plan. We reviewed an annual service user survey which was carried out in September 2016 whereby 290 completed questionnaires were returned regarding the school nursing and health visiting services. Overall the results from this survey were good. For example, 94.81% of health visitor service users felt overall satisfied with the service they received, with 95.66% stating that they would recommend the service to friends and family. We also reviewed a recent service user survey for the learning disability service carried out in 2016. Results from this survey also showed positive outcomes. For example 100% of parents or carers answered "good" or "excellent" to the question "How well do you think the team members listened to your families needs?". Two children were also asked the same questions and both stated either "good" or "very good".

Good practice

- The service offered the family nurse partnership (FNP) programme, which was a voluntary service for under 20's who were expecting their first baby and were registered with a general practitioner (GP) in Ipswich. Each service user was allocated a family nurse, who was a qualified health visitor and had completed further training in FNP, who visited them frequently during the antenatal and postnatal period, until the child was two years of age. FNP nurses told us that they had regular psychologist supervision and that psychologist support was also available to people using the FNP service.
- "Family 2020" had recently been launched which was a "five year partnership plan to transform the way that families are supported in Suffolk – with three changes to the to the way we [Suffolk County Council] design and deliver services". These three changes included improving the understanding and anticipating of

Summary of findings

families' needs, developing early help intervention to target individuals and creating a single point of access manage demand and make best use of system resources.

- In November 2015 the school nursing service introduced a "ChatHealth" service for young people aged 11-19 years. This was a text messaging service to enable young people to confidentially ask for help about a range of issues, or to make an appointment with a school nurse. This was an innovative way to involve younger service users with the service.
- The local authorities safeguarding team was in the process of agreeing a new safeguarding electronic records system, of which the children and young people's service were going to be able to access (read only) to improve communication between health and social care.
- A recent "Children and Young People's Emotional Wellbeing 2020" transformation plan had been developed. The plan was to transform services and the system that supports emotional wellbeing of all children and young people in East and West Suffolk by 2020. There were ten priorities, one of which was developing a single point of access and assessment for support, focusing on the whole family.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The provider must ensure that all staff have access to necessary policies and procedures.
- The provider must ensure that policies, procedures, guidance and patient literature are evidence-based and up-to-date.
- The provider must ensure that pre-employment records are kept up-to-date.

Action the provider SHOULD take to improve

- The provider should consider reviewing its training and policy regarding the duty of candour.
- The provider should consider making formal arrangements for the ordering and supply of medicines.
- The provider should ensure that it captures and monitors performance outcomes for the school nursing service.

Suffolk County Council

Community health services for children, young people and families

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We did not rate the service. We found:

- Safety performance over time was good, the quality of healthcare records was high, and equipment was serviced appropriately and environments were safe and suitable for purpose.
- The service held monthly "Clinical Quality and Safety Assurance Group" (CQSAG) meetings which were minuted and a supporting monthly CQSAG report was developed.
- Staff demonstrated that they understood their responsibilities to raise concerns and to record safety incidents and near misses. Staff could provide examples of lessons learnt from incidents.
- All health visitors, school nurses and specialist nurses received three monthly safeguarding supervision by a lead safeguarding nurse.
- The majority of staff were up to date with their level three safeguarding children and adult safeguarding training. Compliance was at 91%.
- Staffing numbers in some areas of the service provision were low. Senior managers were aware of this and taking appropriate action to sustain services. Staff we spoke too stated that despite some staffing level concerns they felt they were able to provide safe care.

However;

- There was a lack of training, understanding and policy in relation to duty of candour.
- There were insufficient formal arrangements in place for the ordering and supply of medicines for non-medical prescribing.
- Only 73% of staff said they knew how to access the service's non-medical prescribing policy.

Are services safe?

- Records showed that 78% of staff were compliant with their mandatory training requirements as of January 2017. This was below the service's target (95%). We saw that action was being taken to address this.

Safety performance

- There was an appropriate range of safety information being monitored, with set safety goals and outcomes that fed into service improvement. For example, the service produced a monthly "Children and Young People's Performance Report" which contained a dashboard for each area of the service provision.
- The service also held monthly "Clinical Quality and Safety Assurance Group" (CQSAG) meetings which were minuted and a supporting monthly CQSAG report was developed. This report reviewed incident reporting, complaints, service risk, audit evaluation and training.
- Overall we found that safety performance for the service was good. We have reported further on this, and the reports mentioned, throughout the "safety" section of this report.

Incident reporting, learning and improvement

- Between February 2016 and February 2017 the service had report 174 incidents, of which the most frequently occurring incident categories reported were "consent, communication, confidentiality" and "access, transfer, discharge".
- There had been no serious incidents reported between February 2016 and February 2017, however, during this reporting period the service was involved in a serious case review (SCR). The SCR related to a child mortality which happened in January 2016 whereby the service's health visiting service were one of many organisations involved in providing care to this child. From speaking with senior managers and reading the final SCR, we found that the service fully participated in the SCR where required, that a thorough investigation took place and lessons learnt had been identified.
- Subsequent to the SCR the service was providing a study day which was mandatory for all staff on lessons learnt from this case. Fifteen members of staff we spoke with told us they were booked on to this training.
- The service used an electronic incident reporting system. We saw a supporting incident reporting policy was in place, dated October 2016 with a review date of three years.
- Minutes from the service's monthly "Clinical Quality and Safety Assurance Group" (CQSAG) showed that incidents reported by the service were monitored, analysed, actions needed agreed and progress of any actions required were reviewed. We checked the CQSAG reports for September and October 2016 and February 2017.
- We spoke with 12 members of staff and they demonstrated to us that they understood their responsibilities to raise concerns and to record safety incidents, concerns and near misses. These members of staff told us they were encouraged to report incidents and that they could easily access the electronic reporting form to report incidents.
- We asked ten members of staff, including team managers, to give us examples of lessons learnt following incidents reported. All staff were able to give us an example of lessons learnt. The majority of which related to the serious case review (SCR) reported in January 2016.
- We however found a lack of information to show that lessons learnt were disseminated to staff regularly for example; we checked the "Team Brief" newsletters dated January and March 2017 and found no mention of this. Furthermore, lessons learnt was not a standard agenda on the meeting minutes we checked for two separate teams.
- We saw that safety events involving children and young people fed into service improvement. For example, a senior manager explained to us that following a national safety alert the service had been to all children's centres and ensured that blind cords and plug sockets were in line with these safety alerts.
- Root cause analysis investigations (RCA) were completed as part of the investigation of significant or serious incidents. We reviewed one RCA which related to a "significant incident" reported in June 2016 whereby a baby's weight loss was not monitored and acted upon appropriately and the baby was later diagnosed in cardiac failure with an underlying cardiac condition. The type of incident was classified as "delayed diagnosis" and "moderate" in terms of harm. We found that a thorough investigation took place, with lessons learnt identified. We saw that health visitors were weighing babies and taking necessary action where optimum weight had not been achieved. This practice was in line with the service's "health visiting quality standards".

Are services safe?

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Duty of candour was incorporated into the service's "Children and Young People's Health Services Service User Incident reporting Policy and Procedure" dated October 2016 version 1.1. A senior manager confirmed this policy was up-to-date. We found that whilst the term "duty of candour" was mentioned, there were insufficient details in relation to the legal requirements of the duty and how it applied to the service.
- Two senior managers also told us that staff had not received training on the duty of candour including them. However they were able to explain to us how duty of candour would be triggered and that they would act in accordance legislative requirements.
- We asked nine members of staff and only two of them were able to tell us what the duty of candour meant.

Safeguarding

- Between December 2015 to December 2017 CQC received no safeguarding alerts or safeguarding concerns in relation to the service.
- Records showed that between February 2016 and February 2017 the service had raised 262 safeguarding concerns to the local authority safeguarding team
- There was a "Safeguarding Adult Policy and Operation Guidance" document in place dated April 2015 with a review date of April 2017. This policy contained necessary safeguarding information including how to contact the relevant local authority safeguarding team; and advice and pathways were seen relating to the Mental Capacity Act, forced marriage, honour based violence, human trafficking and PREVENT. PREVENT is part of the Government's counter terrorism strategy to prevent people becoming terrorist and supporting violent extremism.
- We saw on the Suffolk County Council (SCC) staff intranet that there was a page dedicated to children's safeguarding which outlined safeguarding procedures for the service and safeguarding information. There were also links to other relating SCC guidelines such as "Meeting the needs of Children and families in Suffolk: Social Care and Common Assessment Framework Thresholds Guidance" version dated 2015, although there was no month specified. We also saw another document titled, "Thresholds for Children with Additional Needs" however this was also undated. We found that safeguarding children's policy and procedure contained necessary information such as types of abuse, female genital mutilation (FGM), child sexual exploitation (CSE) and how to refer your concerns to the local authority safeguarding team.
- There was a dedicated safeguarding team comprising of a manager, five named safeguarding nurses and a children in care nursing team (previously known as Looked after Children). A manager confirmed that all of the safeguarding team had received level four safeguarding children and adults training and all were either a health visitor or school nurse by background. The team worked across the Suffolk region, excluding the Waveney area which was covered by another provider.
- Records showed that 91% of all staff were up-to-date with their level three safeguarding children and adult safeguarding training. This was slightly below the services target (95%). A manager told us this compliance rate was lower due to a number of new starters who were booked onto and awaiting training.
- We spoke with seventeen members of staff about safeguarding. All of which correctly described what constituted a safeguarding incident, and when and how they would raise a safeguarding concern.
- Staff were also able to give us examples of when they had appropriately raised a safeguarding incident. One example shared with us showed that the nurse's referral led to immediate intervention by the local authority safeguarding team and Suffolk Police to safeguard the children involved.
- All health visitors, school nurses and specialist nurses received three monthly safeguarding supervision by a lead safeguarding nurse. Eleven members of these staff we asked confirmed they had received this support regularly. Safeguarding supervision was also available to all staff as required.
- We saw that a safeguarding alert system was in use within service user's electronic healthcare records. This alerted staff to people who were at risk of abuse or where an ongoing safeguarding concern existed.
- We checked the healthcare records of four children who used the service whereby a known safeguarding

concern was apparent. We saw that appropriate safeguarding risk assessments had been carried out, that staff had discussed the issues present at their safeguarding supervision and there was a care plan in place for the child.

- A senior manager explained to us that the local authority's safeguarding team was in the process of agreeing a new safeguarding electronic records system, of which the children and young people's service were going to be able to access (read only) to improve communication between health and social care.
- We spoke with eight health visitors, all of whom told us that they had six weekly one to one meetings with their line manager whereby a discussion regarding caseload numbers and risk took place.
- There was an annual audit carried out of "randomly selected urgent referrals, including safeguarding referrals", which determined whether the service responded to urgent referrals in line with key performance indicator (KPIs). We looked at the results for this audit from September 2016. 33 records were analysed. Results showed that 85% of referrers received a response by the next working day and 73% of families received a health visiting contact within two working days. The NHS England target for these KPIs was 95% and NHS England state that 50 records should be audited. Despite only 33 records being audited due to data collection issues, results showed improvement compared to the previous year, and action recommendations had been made to assist further improvement.
- We observed notices about safeguarding throughout the two child health clinics we observed. For example, in one child health clinic there was a notice titled, "Are you concerned about a child" which explained types of concerns and how to make a referral to the local authority safeguarding team.
- All staff we spoke with told us they had received "Signs of Safety" training. "The Signs of Safety model is a tool intended to help practitioners with risk assessment and safety planning in child protection cases" (NSPCC, 2017). Senior managers also told us that "Signs of Safety" had been interwoven into various risk assessments within the electronic healthcare record system, for example under safeguarding sections.

Medicines

- There was a policy in place for the management of "Non-Medical Prescribing" within the service which was dated August 2015 with a three year review date.
- The service had a dedicated medicine management board consisting of the deputy lead for nursing and clinical services, community practice teachers, two leads for prescribing and a university lecturer for community practitioner nurse prescribing. Medicine management board meetings took place every three months.
- Training records we were shown demonstrated that 95 health visitors and family nurses were trained and competent in community nurse prescribing.
- The service provided six monthly prescribing updates for non-medical prescribing staff. It was mandatory for such staff to attend a minimum of one per year. Records showed that 100% of staff were up-to-date with this training.
- We requested to see the service level agreement in place with the local pharmacy that medicine was obtained from. However we were only provided with the "Protocol for Emergency Hormonal Contraception Supplies" for school nurses, which was dated March 2017 with no review date. We were not assured that the process for the ordering and supply of medicine was suitable due to a lack of formal arrangements in place.
- Multivitamins for children and pregnant women were distributed and sold by the service. We saw that there was a flow chart in place for the purchasing and selling of vitamins dated July 2016. There was also a vitamin prompt sheet for staff to remind them about dose of vitamin required with supporting Department of Health guidance also dated July 2016. However both the flow chart and prompt sheet had no review date.
- School nurses were also qualified to supply and administer two emergency hormonal contraceptive medicines. There were patient group directives (PGDs) in place for both of these medicines dated August 2016 with review dates of August 2018.
- We saw that multivitamins were stored safely and securely in one health visiting team office we checked. There was also a record kept to show number of stock and each time vitamins where sold there was an audit trail to show by what health visitor.
- We checked two health visitor's prescribing pads and found that these were used and stored safely.

Are services safe?

- A non-medical prescribing audit was carried out in October 2016. This involved 54 non-medical prescribing staff completing a survey. Results showed 95.8% of staff had a copy of the Nurse Prescribing Formulary (NPF), 100% of staff reported they kept their prescription pad in a secure locked place, however, only 73% of staff said they knew how to access the service's non-medical prescribing policy. The audit report contained recommendations and showed that the audit would be repeated in three years.

Environment and equipment

- We reviewed the servicing records for 388 pieces of equipment used by the service, including scales and audiometers. These records showed that all equipment was up-to-date with servicing requirements.
- We also visually checked five pieces of equipment and found that they were clean, appeared in good condition and had servicing stickers on showing servicing had taken place in the last 12 months.
- There were service level agreements (SLA) in place for the servicing of equipment. For example, we reviewed an SLA for weighing scale calibration which was signed and dated appropriately.
- We visited two child health clinics during our inspection and observed that environments were clean, clear of clutter and child friendly. These environments also ensured the safety of patients and families. For example there were buzzer entry systems for entry into child health clinics.
- We saw that waste was segregated appropriately. This included dirty nappies being disposed of in yellow clinical waste bins in the child health clinics we visited.
- Senior managers told us that risk assessments had been carried out for each child health clinic location. We checked one risk assessment which was thorough, had mitigating actions and a review date. We also saw that the mitigating actions had been actioned. For example trip hazards were avoided by ensuring the environment was tidy.
- Staff told us that information technology needed to be better throughout the service. However we saw that an "IT Action Plan" was in place dated November 2016. This showed that the service aimed to "Improve health staff access to robust and appropriate IT solutions / equipment" by actioning a number of issues, including ensuring that all staff will have a smartphone allocated to them by April 2017. Records showed that the action plan outcomes were being monitored and achieved overtime.

Quality of records

- There was a "Record Management and Information Handling Policy" in place, dated November 2016 with a review date of three years. This policy outlined staff's roles and responsibility in relation to record management processes.
- We saw that women and babies healthcare records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- The service used an electronic records system, and paper "red child health" books were also used and kept by the parents and carers of babies and children. We checked five children's red books during child health clinics and found that necessary information, such as weight and any issues apparent were recorded in the book. This information was also entered onto the child's electronic health record by the health visitor after the clinic.
- The service operated a "paperless" organisation whereby healthcare records were electronic, and paper-based records were destroyed once the data was entered or scanned onto the computerised system.
- We observed that staff's computers were locked when not in use, and that all computers were password protected.
- We checked the electronic healthcare records of 15 people who had used the service. We also reviewed five red child health books during the child health clinics we observed. We found that records were accurate, complete, legible, up-to-date and signed/electronically signed.
- Between April to September 2016 a health visiting and school nurse record keeping audit was carried out. Seven school nursing records and 42 health visiting records were audited. Overall audit results were good with some improvement actions identified. For example, key findings from school nurse record audit showed 100% compliance with the service's record keeping standards, that only one record of seven was

not recorded within three days of the care episode taking place, however, that only 57.14% succinctly summarised the assessment, analysis, action, pathway, outcome and review on each entry.

Cleanliness, infection control and hygiene

- There was an "Infection Control Policy" in place date April 2015 with a three yearly review date. However this did not make reference to up-to-date evidence based practice, including "Healthcare-associated infections: prevention and control in primary and community care; CG139" issued by the "National Institute of Health and Clinical Excellence" in 2017.
- We observed two child health clinics being carried out. We found all areas used by the service were visibly clean, including floors, surfaces and seating.
- We saw that staff cleaned their hands in line with the "World Health Organisation's Five Moments of Hand Hygiene". For example, during child health clinics we saw that the health visitor cleaned their hands with hand sanitiser between service users. Baby scales were also cleaned appropriately between use and there was appropriate hand washing facilities in both of the child health clinics.
- The service completed an annual hand hygiene audit. We checked the results from the July 2016 audit which showed that 88.78% of staff "passed" the audit. However the audit report did not show what aspects of hand hygiene were being monitored.

Mandatory training

- Mandatory training consisted of infection control, essential information management, basic life support, manual handling, fire safety, equality and diversity, conflict resolution and safeguarding adults and children. Training was a combination of both e-learning and face-to-face based learning in classrooms.
- Records showed that 78% of staff were compliant with their mandatory training requirements as of January 2017. This was below the service's target (95%). We saw that action was being taken to address this.

Assessing and responding to patient risk

- We checked the electronic healthcare records of 15 people who had used the service. This ranged from babies, school children and mothers. We found that comprehensive risk assessments were carried out in all cases with plans of care developed accordingly, and risk managed effectively.
- We asked six members of staff how they would respond to a child displaying feverish signs. All staff told us they would assess the child thoroughly and give advice to the parent/carer accordingly dependent on assessment, including referring the child to a doctor as required. Staff were able to give examples of where they had given such appropriate advice which was in line with evidence-based practice, such as "Fever in under 5s: assessment and initial management; CG160" issued by NICE in May 2013.
- Child protection medical assessments were not carried out by this service.
- We asked staff about handover arrangements between teams and externally when people using the service transferred out or were discharged from the service. All staff told us that handover would be verbal if the person transferred out of the area and if the person had any risks identified, for example, there were child protection concerns. We also saw that a transfer out and discharge summary section was available on each of the 15 healthcare records we checked.

Staffing levels and caseload

- Overall the service had 346 established staff in post which was equivalent to approximately 251 whole time equivalents (WTE).
- Data from October 2015 to October 2016 showed that the turnover (staff leavers) rate for staff was 9.2% which equated to 8.7% WTEs.
- Workforce planning for health visiting and school nursing was carried out using the service's "Suffolk Model" for deployment of health visitors and school nurses. Whereby for the health visitor caseload this was established using a weighting formula based on Indices of Multiple Deprivation (IMD) and adapting this to fit the actual resource availability within the service. The same method was used for school nurses but opposed to using IMD data, Income Deprivation Affecting Children Index (IADIC) data was used instead.
- We checked the caseload numbers for five health visiting teams and found that four out of five teams' caseloads were in line with planned numbers. For example, in East Ipswich team the planned average caseload per full time equivalent (FTE) HV was 264 and

the actual average caseload number was 264. However in the Haverhill team the planned average FTE HV caseload was 344 and the actual caseload was 500. There were two vacant posts in the Haverhill team which would improve these numbers when filled.

- We also reviewed information from the service to show caseload numbers for school nurses and the children in care (CiC) teams. For school nurses, three out of the four area teams were in line with planned numbers with a forecast to increase staffing in both West and Central and South Suffolk areas by July 2017.
- Within the CiC team, the average caseload per FTE was 241 (which included children residing in Suffolk and those out of county). A business case was in process to support the possible recruitment of a further three FTE registered nurses to work within the CIC Nursing Team. This would then take caseload sizes down to around 100 children per FTE Nurse.
- Senior managers confirmed to us that agency staff were no longer used, however, that bank staff were used regularly, of whom were mostly previous employees of the service who had for example retired. Records showed that from 01 August to 31 October 2016, 187 (1.4%) of shifts were completed by bank staff.
- Staff we spoke with during our inspection told us they were concerned about a lack of staffing in their area. For example, one member of the school nurse team told us, "we are short staffed and have been working under a lot of pressure for a long time", a health visitor said "we are only able to deliver a level one health visiting service", and another member of staff told us that the children in care team have "too many children on their caseload and that this need is being reviewed". All staff told us that despite these staffing levels they felt they were able to provide safe care.
- Prior to our inspection the service openly told us that staffing numbers within some areas of the service were low, and in addition that the, "health visiting, school nursing and family nurse partnership services were subject to an approximate 7% cut in funding over three years commencing April 2017". We however saw that the service was taking appropriate action. There was a "Recruitment and Retention Plan" in place dated September 2016, which aimed to improve both the recruitment and retention of staff through a number of agreed outcomes and coordinating actions. For example, in terms of recruitment, one outcome was to ensure that job advertising continued to happen monthly of which the updated action plan showed was happening. In terms of retention of staff, one outcome was to reduce staff sickness by introducing stress tool kits for all health visitor, school nurse teams and individuals, and all manages had undergone workshops to assist them to manage staff sickness effectively. This action had been marked as "completed".
- Senior manages explained to us that the school nursing service had recently been restructured. We reviewed the "School Nurse Service Restructure" plan dated 2017 which was due to come into action in the months ahead. This included the formation of five district school nurse teams. This service restructure followed a consultation whereby all school nursing staff were invited to participate. We spoke with five members of the school nursing service, all of whom told us they participated in the consultation and received feedback throughout the consultation process. However all these staff raised concerns to us that the restructure was a concern to them as it meant the school nursing service would be limited in terms of service offered.
- There were also plans to redesign the health visiting servicing whereby a consultation was planned to be commenced in October 2017.
- Records showed that the staffing vacancy rate for the service as of October 2016 was 8.45% (excluding seconded staff).
- Records from between November 2015 to October 2016 demonstrated that staff sickness rates were at 6.07% overall for the service.

Managing anticipated risks

- Lone working arrangements were found within the provider's "Safety, Health and Wellbeing" policy dated March 2016. Lone worker arrangements varied between teams.
- We saw that the electronic healthcare records system captured information about each lone worker's whereabouts. For example, if a family support practitioner was out on a home visit the address and time of visit was recorded. In one health visiting office we saw that the duty health visitor for the day kept a record of all the teams' whereabouts and ensured every member of staff had returned from their visits by the end of the working day.

Are services safe?

- Some staff also told us that they had a code word they would use if they needed support during a home visit, for example, if they felt unsafe. They would call the work office and say the code word which would trigger an alert.
- The health visiting service was operating a level one service at the time of our inspection. This meant that the service was limited to completing/actioning all safeguarding alerts, CiC health assessments, new birth visits, six to eight week reviews, urgent universal plus follow up with a health concern, transfer in visits/clinics, accident and emergency (A&E) and domestic abuse notifications, nine to 12 months reviews, child health clinics, antenatal visits for universal plus and partnership plus service users, mandatory training and all meetings. This was in line with the services, "Management of Caseloads within a Specialist Community Public Health Nurse (SCPHN) Team in Suffolk County Council" and was due to a number of vacant caseloads whilst recruitment was ongoing. A vacant caseload was defined as a situation, "where there was no substantive health visitor or school nurses for a period of 4 weeks or more" and "in a situation of a corporate or shared caseload, a vacant caseload is defined as a reduction in allocated SCPHN hours for a period of 4 weeks or more of 50% and can include sickness, annual leave and maternity leave absence".

Major incident awareness and training (only include at core service level if variation or specific concerns)

- There was a "Business Continuity Plan" in place for the children and young people's (CYP) service, which was created December 2016 with an annual review date. This outlined what action the service would take to maintain critical services and activities in CYP in the event of major disruption, such as IT loss and loss of transport due to severe weather. Senior managers we spoke with were aware of the business continuity plan.

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 did not rate the service. We found:

- Service users had their needs thoroughly assessed, care goals identified and care plans were in place accordingly.
- Breastfeeding rates were above target and improving overtime, blood spot screening for eligible babies was 100% and 97% of children receiving care from the learning disability nursing team were provided with a care plan after the first definitive treatment date.
- Staff were competent and access to additional training was good. There was an established number of mentors and community practice teachers (CPTs) to provide support, training and clinical supervision.
- 95 health visitors and family nurses were trained and competent in community nurse prescribing, allowing them to prescribe from the Nurse Prescribers Formulary (NPF) for Community Practitioners.
- There was evidence of effective multidisciplinary (MDT) working and collaborative pathways for service users.

However we also found that;

- The majority of policies, procedures, guidelines and patient leaflets we reviewed lacked either a date of issue or review date, which meant we could not be assured they were based on the most up-to-date evidence.
- Five out of eight members of staff we spoke with were not able to easily access policies and procedures on the service intranet.
- Some of the Healthy Child Programme (HCP) outcomes for 0-5 years were not being met due to lack of staffing numbers, and insufficient performance data for school nursing services was being captured and monitored.
- At the time of our inspection the school nurse dashboard reporting system was under re-development which prevented outcomes for children using the school nurse service being measured.
- Not all service records were fully complete; certain dates were missing from some employment records such as when a Disclosure and Barring Service (DBS) check had taken place or a reference was obtained.

Evidence based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation were identified through an audit group and a manager who led on policy. The manager participated in local groups whereby new and emerging guidelines, such as those issued by "The National Institute of Health and Clinical Excellence" (NICE), were discussed. This manager then fed back to the audit group where discussions took place as to whether changes were needed to existing policy and procedure. The policy group then met quarterly to discuss any issues emerging from the audit group and drafted new policy and procedure as required. The "Clinical Quality and Safety Assurance Group" (CQSAG) ratified policy and procedures and disseminated to all staff as necessary.
- We asked eight members of staff to show us how they accessed policies and procedures, however, only three members of staff were able to access the service's up-to-date policy and procedure system on their staff intranet. This meant not all staff could access policies and procedures relevant to their role. For example, we asked one member of staff to search for jaundice related policy or procedure and they were unable to find this information. However another member of staff could. We raised our concern to three senior managers who told us that all staff were sent an email reminding them to create a short cut on their computer to allow access, and that they would be taking subsequent action to resolve these concerns.
- There were numerous policies and procedures for the service. We checked fourteen policies, procedures and pathways for the service, of which we found that a significant amount did not have a review date or had not been updated to reflect relevant evidence-based practice. For example, the "Infection Control Policy" dated April 2015 did not reference guidelines such as "Healthcare-associated infections: prevention and control in primary and community care; CG139" issued by the "National Institute of Health and Clinical

Are services effective?

Excellence" in 2017. Flow charts and staff prompt sheets for multivitamins did not have a review date and there was lack of policy and procedure in relation to duty of candour.

- We did however see evidence that the service was delivering the "Healthy Child Programme" (HCP). The HCP is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices. The programme also identifies key opportunities for undertaking developmental reviews that services should aim to perform.
- The service had produced a "Health Visiting Operational Framework", which supported the implementation of the HCP (zero to five years) locally. We found that this document was not dated.
- There was also a "School Nursing Service Operation Framework", which supported the implementation of the HCP (five to 19 years) locally. This was dated March 2016.
- We saw that progress against delivering the HCP outcomes for 0-19 years was monitored monthly through a performance dashboard.
- There were numerous pathways built into service user's electronic health care records and these were used as required. For example for people using the health visiting (HV) service there were pathways for universal, universal plus and universal plus partnership. Universal pathways were delivered by the HV team to provide the HCP, support for parents and access to a range if community services and resources. Universal plus allowed a quick response from the HV team when specific expert help was required, including post natal depression, a sleepless baby and weaning. The universal partnership plus pathway provided ongoing support from the HV team plus a range of local services working together with the child and family. This included services from the Family Nurse Partnership team.
- We checked the healthcare records of ten people who used the service and found that all service users were on to the correct pathway specific to their needs, and that their needs had been assessed, care goals identified and care was planned and delivered in line with evidence-based, guidance, standards and best practice.
- We also checked the healthcare records of three children with long-term conditions or complex needs who used specialist services. We found that all of these children had a clear personalised care plan in place which was up-to-date and in line with relevant good practice guidance which set out clear goals for the child. For example, we checked one record for a school-aged child who had epilepsy. We saw that a thorough needs assessment had been carried out for this child, a Team around the Child (TAC) service was being provided including support from an epilepsy specialist nurse, community paediatrician and a family support worker who was allocated to the family. There was also an up-to-date care plan in place for this child.
- We reviewed the "Health Visiting Quality Standards for Family Health Needs Assessments" version two which had last been reviewed in June 2015. The purpose of this standard was to define the quality of care to be achieved when undertaking family health need assessments. This contained information about jaundice management in new-borns, ankyloglossia (tongue tie) and growth measurement, plotting and interpretation.
- There was a "Policy for Continence Care and Home Delivery Service" however the last date of review was December 2015 and the document was reading as in "draft" format. This did however make reference to the most up-to-date guidelines on the management of bedwetting in children and young people issued by "The National Institute of Health and Clinical Excellence" (NICE) in 2010.
- We asked nine members of staff about the Mental Health Act (1983), all of which confirmed they had received training on the MHA in the past year as part of safeguarding training, and they demonstrated they understood the legislation sufficiently and their role within it.
- There was a "children in care" (CiC) team. The team offered a specialist health assessment, known as a review health assessment, to all CiC children under the care of Suffolk County Council, with the exception of the Waveney area where the service is provided by an external healthcare provider. Alongside the assessment the CiC nurse team offered physical, emotional and mental health advice; information about the effects of a child's health history on their development referrals for treatment; monitoring of identified health needs; preventative measures (e.g. immunisation) advice and

guidance on promoting health and personal care (e.g. sexual health advice, adolescence, e-safety) and a "Health Passport" for care leavers which provided a summary of a young person's health history. The term children in care (previously looked after children) describes children and young people who are cared for in a foster care or in a residential placement (i.e. in an institution such as a children's home).

- There was a "Specialist Educational Needs and Disability (SEND) strategy "in place dated 2015 -2018. In December 2016 Ofsted and CQC carried out a out a joint inspection to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014. Whilst the report identified some strengths it raised a number of concerns in relation to practice. This included but was not limited to: the needs of many children and young people were not effectively met; ineffective governance and leadership; and the 2015 to 2018 strategy for children and young people with special educational needs and/or disabilities was under planned review and it had not driven the reforms effectively. Ofsted and children's service inspectors from the CQC requested a report from the provider and were continuing to monitor this aspect of service provision at the time of this inspection in March 2017.

Nutrition and hydration

- We checked the healthcare records of ten babies; this was a combination of electronic and red child health records. We saw that each of these babies' care plans included an appropriate nutrition and hydration assessment and management plan. For example, during child health clinic we observed that at each contact the health visitor (HV) asked the parent about the babys' feeding, what and how often.
- All staff we spoke with confirmed they had received training in breastfeeding. HVs told us that they and Family Support Practitioners were available to support with breastfeeding as and when women required. We also saw that there was additional breastfeeding support available for women, for example, at one child health clinic there was a notice advertising local "breastfeeding drop-in sessions" which were delivered by the service.
- Performance data showed that breastfeeding rates at six to eight weeks postnatal where improving over time in relation to the service's target (50%); October (43.7%), November (49.6%), December 2016 (46.6%) and January 2017 (50.4%).
- Performance data from the Family Nurse Partnership (FNP) team showed that breastfeeding rates at 12 months (16.7%) were better than the national average (5.5%).
- The service employed an infant feeding coordinator who was training to be a lactation consultant. This member of staff had been in post for the service for approximately one year.
- The service was working towards achieving accreditation stage one under the "Unicef Baby Friendly Initiative". Accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Services implement these staged standards over a number of years and an external Unicef assessor assesses them at each stage.
- Throughout the child health clinics we observed numerous notices and leaflets available to parents and carers giving information on weaning and nutrition. Family Support Workers also led weaning groups regularly from child health clinics. We reviewed five leaflets none of which had a date of production or review date on them. This meant we could not be assured these leaflets were based on the most up-to-date evidence available.
- School nursing teams delivered the "National Child Measurement Programme" (NCMP) to all school aged children in the area. Where a child was considered overweight they were referred to the "One Life Suffolk" group, which assisted children in losing weight. This service was for children aged two to 18 so other services were able to refer younger children to this service as well.

Technology and telemedicine

- The service used a single shared electronic health record (EHR) system, which could be used remotely, accessed by all authorised staff, and data could be

shared securely across services that had gained service user permission. Staff told us that local GPs had access to this system as did other services such as speech and language therapy (SALT).
- The service did not use a telemedicine service.

Patient outcomes

- The service monitored its performance against a number of outcomes, including those set by Commissioners and those within the Department of Health's "Healthy Child Programme". Outcomes were reported via a monthly "Children and Young People's Performance Report" which contained key performance tables to show compliance against them.
- Within health visiting services in January 2017 some targets were being met. Targets were set at 90% for the following described outcomes. For example, 89.3% of new birth visits were completed between 10 and 14 days post natal; 90.6% of six to eight post natal reviews; 84% of 12 month child reviews were completed and 83.0% of 2 and a half year reviews were completed. Results for November and December 2016 were similar for all these outcomes.
- At the time of our inspection the health visiting service was operating a level one health visiting service in line with its vacant caseload policy. This was due to reduced staffing numbers in some areas whilst ongoing recruitment took place. This meant that some of the HCP outcomes were not being met. This included antenatal contacts completed after 28 weeks pregnancy which in January 2017 only 29.1% were carried out against a target of 67%; and the three to four month face to face review completed for universal plus and universal partnership plus clients was 43.9% in this same reporting period which was significantly below the target (90%).
- Within school nursing services in the past year "National Child Measurement Programme" (NCMP) data, that is weight and height measurements, had been collected for 94.86% of reception children and 96.20% of year six children. Records showed that the service was meeting national and local NCMP targets. Other school nursing outcome data was difficult to interpret as a significant amount of data was missing and there was a lack of set targets for each outcome specified. Records did show that at the time of our inspection the school nurse dashboard reporting system was under re-development. However this meant we were unable to determine whether outcomes for children using the school nurse service were good.
- 100% of all "eligible" babies received blood spot screening between April 2016 to December 2016. This was above the service's target of 95%.
- In January 2017, 97% of children receiving care from the learning disability nursing team were provided with a care plan (that is a care plan after first definitive treatment date). The months preceding were similar; November (99%) and December 2016 (97%). The target was 100%.

Competent staff

- There was a comprehensive induction programme and supporting framework in place for all newly qualified and new to area staff. The supporting framework titled, "Local Induction Programme for Newly Qualified or new to area health staff" and was dated September 2016 with a review date of September 2017.
- A preceptorship policy was also in place dated September 2014 with a three yearly review date. This policy applied to all registered professionals working in children and young people's services. This policy contained a framework for the preceptorship programme, guidance for staff and a set of competencies required to be completed within the first six months of employment.
- There were also additional role specific competencies in place for staff including "Community Staff Nurse Skills Framework" competencies for health visiting. These competencies ranged from record keeping to being able to make referrals to other agencies. Whilst the "Community Staff Nurse Skills Framework" was dated October 2015 there was no review date on this document.
- New Family Support Practitioners (FSP) completed competencies relative to their job role. We saw that there was a supporting competency framework in place and four FSP's we spoke with confirmed they had either completed these competencies or were in the process of.
- Records showed that 86% of staff, including senior managers, had received an appraisal as part of their

annual performance development review (PDR) in the past year. 11% did not qualify for a PDR as they were new starters and were completing their probationary period. The other 3% were on long term leave.

- We spoke with fifteen members of staff all of who told us that training opportunities within the service were either "good" or "excellent". For example, one FSP told us they had recently completed infant massage training. One member of staff told us, "we are very lucky here we get a lot of training", another member of staff from the learning disability nursing team told us, "we get a weekly email outlining training opportunities available, we have all done lots of additional training".
- 95 health visitors and family nurses were trained and competent in community nurse prescribing, allowing them to prescribe from the Nurse Prescribers Formulary (NPF) for Community Practitioners.
- 119 health visitors and school nurses had completed mentorship for practice training allowing them to mentor students.
- There were also five community practice teachers (CPTs) employed for health visiting which was equal to 4.4 whole time equivalents (WTE) and two CPTs for school nursing equal to a WTE of two. All CPT posts were filled at the time of our inspection. The CPT's role was to design programmes of learning for student health visitors and school nurses, supporting and supervising these students, and making judgements on the proficiency of each student's competence leading to qualification.
- We spoke with twenty members of staff and they all confirmed they had six weekly one to one meetings with their line manager.
- Staff also told us that they had access to clinical supervision as required.
- We randomly selected 19 members of staff's pre-employment records to check if suitable pre-employment references had been carried out. The service could not show the date that two of these members of staff had completed a Disclosure and Barring Service (DBS), although they told us these had been completed, and four members of staff had only one reference opposed to two. This was not in line with the service's policy and procedure as described by senior managers. There was however evidence of registration checks for all registered staff.
- A senior manager confirmed that monthly registration checks for registered staff took place, and that they maintained a record of this.
- A manager was able to give us two examples whereby the service effectively managed poor staff performance. This involved supporting staff to improve where possible.

Multi-disciplinary working and coordinated care pathways

- Throughout our inspection, by talking to staff, we found evidence of multidisciplinary (MDT) working across teams within the children and young people's service and with other providers. For example, we spoke with a nurse from the children's disability nursing team who described a recent case whereby a child was living with a learning disability and the multi-agency service which were involved, including speech and language (SALT) and sensory therapy, who worked effectively together.
- A Family Support Practitioner (FSP) described their caseload. They were able to give us multiple examples of "Team around the Child" (TAC) cases they had been and were involved with, whilst demonstrating MDT working and co-ordinated care pathways.
- Staff across all teams described various additional services which were available to children if assessed suitable. This included access to Child and Adult Mental Health Services (CAMHS) tier three and four, community paediatricians, SALT and occupational therapy.
- We checked the healthcare records of four people who had used the service with complex needs and found evidence of MDT working and coordinated care pathways. For example, one school-aged child's healthcare records showed that there were suitable professionals involved in this person's care including social care, school nurses and psychology. We saw this person's healthcare records contained input from all these professionals, that there was a lead professional coordinating the child's care and an up-to-date and suitable care plan was in place. We also found that all the professionals involved where able to access to the electronic healthcare record.
- The service was part of the "Multi-Agency Safeguarding Hub" (MASH) for Suffolk, which is a range of organisations in Suffolk with responsibility for safeguarding adults and children. Organisations included the police, health services, district and borough housing services, education, probation and the

youth offending service. MASH is a national model which has been developed as a result of lessons learnt, particularly those lessons highlighted by reviews of serious safeguarding incidents across the country.

Referral, transfer, discharge and transition

- Staff were able to describe the process for referring a child, young person or family that required access to additional services. For example, one community nurse described the process of referring children to the enuresis service. The Enuresis Service offers countywide support for children and young people with concerns about bed-wetting.
- We saw there were transfer templates built in to service user's electronic healthcare records, so that if a person was for example transferred to another service because they moved, the relevant lead healthcare professional would complete the template and contact the new service to inform them of the transfer in. We saw one transfer in template for a child that was fully completed.

Access to information

- Staff told us they had access to the electronic healthcare system used, and could therefore access all the records of children, young people and families they were allocated to work with.
- During our inspection we requested electronic healthcare records of children, young people and families where required, and numerous pieces of data about the service. These were supplied to us promptly.
- Overall all staff we spoke with told us there was good communication between internal and external staff, and that necessary patient information such as results of a babies' hearing tests, were available on the electronic health record system when completed.
- One staff member said that the electronic healthcare record system "made it very easy to communicate with other teams both inside and out of the service", another member of staff said, "Communication internally and externally is excellent".
- We saw that some health visitors were based in children's centre and others were based in health centres. These staff told us they liked being based in such buildings, where other children and young people's services were delivered from, because it improved multidisciplinary (MDT) team working.
- The majority of staff we spoke with told us that they were awaiting a laptop from the service to allow them to work remotely, however, that they could still access work computers at their work office.
- Parents and carers of children up to the age of five kept their child's red book (record of child health book).

Consent

- There was an up-to-date "Record Keeping Policy" dated June 2015 with a three yearly review date. Consent was covered within this policy and included the need to obtain valid consent, how to legally obtain consent for children and how consent should be recorded.
- Senior managers told us that training on consent, Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act were covered within staff's mandatory staff training. Records showed that 78% of staff had completed this training.
- We spoke with four members of staff about gaining consent for children and young people who were under 16. All of these members of staff demonstrated to us that they understood their responsibility in gaining consent prior to undertaking an examination or treatment. Staff could also describe the differences between Gillick competence (the judgement of children to consent to medical treatment) and the Fraser guidelines (guidelines specifically associated with contraception and sexual health advice) and knew when each was applicable.
- School nurses explained to us that when they supplied and administered emergency contraceptive medicines to girls, in line with the service's patient group directives (PGDs), they always recorded whether consent was obtained within the child's electronic healthcare record system.
- Eleven members of staff we spoke with understood the terms "mental capacity" and "best interest decisions", and demonstrated they acted in accordance with the Mental Capacity Act. We also asked these staff about the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty, all of which provided satisfactory answers.

Are services caring?

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

Summary

We did not rate the service. We found:

- We observed staff treat people who used the service with dignity, respect and compassion.
- People who used the service told us that staff were always caring toward them and their family.
- Service users also told us that they understood and felt involved in their care.
- The service user annual survey showed good results overall. For example, 100% of parents and carers of school aged children felt they were listened to and treated with respect.
- Parents had a designated health visitor and had been given their health visiting teams contact number so as they could always call the service for support Monday to Friday between 9-5pm

Compassionate care

- We observed two child health clinics in different areas and checked how staff interacted with people who used the service. We found that at all times staff acted in a compassionate and respectful way towards people. For example, one mother told a health visitor that she was worried about her child not sleeping well at night. We saw that the health visitor was kind and compassionate in their response and gave appropriate advice and reassurance, offering the women further support if she wished.
- We also observed that staff took time to interact with children and young people and those close to them. During a child health clinic we saw that a family support worker was situated in the waiting area of the clinic. They were speaking with parents, offering support and seen interacting with babies.
- From speaking to staff we were assured that children were seen as "children first and foremost". One member of staff told us, "The child is at the centre at all times, at the heart of what we do".
- We saw that health visitors ensured the rooms where child health clinics were delivered, were warm and they put paper towel over the scales, to ensure that the scales were not cold in an attempt to prevent babies crying.
- We spoke with seven parents of children at the two child health clinics we attended. All of whom told us that staff were kind and caring. One parent told us that staff were, "very supportive", and another said, "staff are always friendly and welcome you here".
- An annual service user survey was carried out which covered health visiting and school nurses only. We looked at the latest survey results from September 2016. 138 completed questionnaires where returned for the health visiting service and 152 for school nursing. Results that related to the health visiting service included: 94.8% of service users felt overall satisfied with the service they received; 95.6% stated that they would recommend the service to friends and family and 70% said they were seen on time.
- School nursing service results included: 92% of carers and young people found the school nurse advice helpful and would recommend the service to family and friends; 81.4% of parent and carers reported it was easy to contact the service; while only 46.8% of young people said the same; 100% of parents and carers felt they were listened to and treated with respect and 92% of young people felt welcomed and listened to. We saw that there were action recommendations concluded at the end of the report. One of which included that in the 2017 survey, children in care, enuresis and learning disability service users would be involved.
- We also reviewed a recent service user survey for the learning disability services. The survey was carried out between October 2015 and March 2016. 15 surveys were returned which was a response rate of 54%. Results showed positive outcomes. For example 100% of parents or carers answered "good" or "excellent" to the question "How well do you think the team members listened to your family's needs?" Two children were also asked the same questions and both stated either "good" or "very good".

Understanding and involvement of patients and those close to them

- All seven parents we spoke with told us that they understood their child's and their own plan of care, and

felt involved in any care planning. One parent told us that staff, "always ask what they [the parent] want", and other parent told us, "my health visitor explains everything to me and well".
- These parents also told us that they had a designated health visitor and had been given their health visiting teams contact number so as they could always call the service for support Monday to Friday between 9-5pm.
- We checked the healthcare records of 15 people who had used the service and found that any clinical letters on each record where also copied in to parents and carers.

Emotional support

- The caseloading model of care used by the different teams within the service meant that there was largely continuity of care from the same member of staff or team was good. All six parents we spoke with told us that they had a designated health visitor, knew their health visitor's name and confirmed continuity of care was good. Furthermore during our observations of child health clinics we found that the health visitor and parent attending were familiar with one another and there was a good rapport between them.
- The service offered the family nurse partnership (FNP) programme, which was a voluntary service for women under 20, who were expecting their first baby and were registered with a general practitioner (GP) in Ipswich. Each service user was allocated a family nurse, who was a qualified health visitor and had completed further training in FNP, who visited them frequently during the antenatal and postnatal period, until the child was two years of age. FNP nurses told us that they had regular psychologist supervision and that psychologist support was also available to people using the FNP service.
- Health visitors told us they provided children and their families with additional home visits if required. One parent told us that they experienced postnatal depression and subsequently their health visitor had given them additional and regular visits, and called them in between visits to check how they were.
- We also checked the healthcare records of twelve other people who used the service and found that emotional wellbeing had been assessed regularly.
- Between April 2016 and January 2016 82.1% of post natal women had their mood assessed by a health visitor. This was slightly below the service's target of 86%.

Are services responsive to people's needs?

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

Summary

We did not rate the service. We found:

- Services were planned and delivered which met the needs of local people, including those with different needs and in vulnerable circumstances.
- People could access the service in a timely way.
- There were examples of innovation in terms of a text messaging system used for school aged children.
- There was a range of services available to support people emotionally.
- Complaints were low and handled effectively.

However;

- No health profile had been completed by school nurses for the schools they were allocated to.

Planning and delivering services which meet people's needs

- Services offered included: health visiting, school nursing, special school nursing, named nursing for safeguarding children, children in care nursing, community learning disability nursing, enuresis and family nurse partnership services. These services were delivered from a range of community settings including health centres, children's centres, schools and services user's homes.
- Staff we spoke with could describe the particular needs of the area they worked in and how services were planned accordingly. For example, a senior manager explained that there was a high number of a particular minority ethnic group in one area and subsequently a clinic had been arranged with a translator present for these children and their parents or carers.
- School nurses confirmed that there had been no formal health profile completed by the service for the schools they provided a service to which meant that there was the potential to miss opportunities to identify the needs of the local community.
- We found that services were designed to meet local needs. For example, health visiting caseload numbers were calculated based upon workings including "Indices of Multiple Deprivation" (IMD) and therefore areas with higher need were allocated more health visiting services.
- At the time of our inspection the school nursing service had been reviewed and a restructure was soon to be implemented. Five members of the school nursing service told us that they had been involved in the consultation process and were provided with regular updates during the process.
- On the provider's website there was information for parents, carers and service users which encouraged them to be involved in public consultations. We saw that parents, carers and service users had the opportunity to feedback their views on the health visiting and school nursing services.
- There was evidence that Suffolk County Council (SCC) linked with commissioners, other providers and relevant stakeholders involved in planning services. For example, we saw that SCC carried out a local Joint Strategic Needs Assessment (JSNA) for Suffolk, which incorporated all of children and young people's services. Numerous programmes and projects were designed based on such assessment of need.
- For example, "Family 2020" was a "five year partnership plan to transform the way that families are supported in Suffolk – with three changes to the to the way we [SCC] design and deliver services". These three changes included improving the understanding and anticipating of families' needs, developing early help intervention to target individuals and creating a single point of access to manage demand and make best use of system resources.

Equality and diversity

- Both of the child health clinics we observed were disabled and buggy accessible. This ensured that all members of the community could access these services.
- Staff told us that they had access to written, telephone and face to face translation services and three members of staff explained to us how they had used these services in the past.
- We saw leaflets within clinic areas which informed families about local healthcare services and this information was in a range of languages.
- Data demonstrated that 86% of staff were up-to-date with the three yearly equality and diversity mandatory training.

Are services responsive to people's needs?

- We reviewed the provider's annual "Equalities and Inclusion: Our Corporate Story: Annual report 2015-16". This report demonstrated SCC's "approach to the duties outlined in the Equalities Act (2010) and highlights the progress we have made to take into account the needs of people from the nine protected characteristics".

Meeting the needs of people in vulnerable circumstances

- There were numerous additional services available to children, young people and their families both within the service we inspected and by SCC. For example, internal services offered included the family nurse partnership (FNP) service which we have described fully on the "emotional" subheading of the "caring" section within this report, and the learning disability nursing team service that supported children living with learning disability and their families.
- There was also the child in care (CiC) team who offered a specialist health assessment, known as a review health assessment, to all looked after children (LAC) under the care of Suffolk County Council , with the exception of the Waveney area where the service is provided by an external healthcare provider. Alongside the assessment the CiC nurse team offered physical, emotional and mental health advice. This included information about the effects of a child's health history on their development referrals for treatment; monitoring of identified health needs; preventative measures (e.g. immunisation) and advice and guidance on promoting health and personal care (e.g. sexual health advice, adolescence, e-safety). A Health Passport was also in place for care leavers which provided a summary of a young person's health history.
- In November 2015 the school nursing service introduced a "ChatHealth" service for young people aged 11-19 years. This was a text messaging service to enable young people to confidentially ask for help about a range of issues, or to make an appointment with a school nurse. This was an innovative way to involve younger service users with the service. The service stated it had "initiated more conversations in January 2017 per 1000 users via ChatHealth than any other service nationally".
- We checked the healthcare records of 15 people who used the service and saw that their individual, physical, emotional and social needs were recognised and responded to. We also saw that cultural and religious needs had been assessed.
- We checked the healthcare records of three people with complex needs. We found that the service took account of the needs of different people, including those in vulnerable circumstances; carried out necessary risk assessments and appropriate care plans were place for these people.
- We checked the healthcare records of three women who had recently had a baby and found that all had received a postnatal mental health assessment with appropriate plans of care in place.
- We reviewed the healthcare records of two women who had suffered post natal depression. We saw that appropriate and ongoing assessment had taken place for each woman, and that both had received additional support including further health visiting visits and signposting to appropriate children's centre services.
- The service provided us with a list of advocacy services it promoted.

Access to the right care at the right time

- Six people who used the health visiting service told us that access to the health visiting service was streamlined in that they received contact from a health visitor following the birth of their baby, that clinics ran on time and that they had the contact details of their health visitor.
- Data from the service user survey, conducted between October 2015 to March 2016, and related to the learning disability nursing team included questions around access to services. The survey asked, "how would you rate the team's response time" to a number of issues such as "your phone messages" and "requesting a meeting". Fourteen parents and carers were asked and all replied "good" or "excellent".
- The service monitored access and flow of its service monthly and reported on this via the monthly "Children and Young People's Performance Report". We have reported on this further under the "effective" section of this report.
- During April 2016 to January 2017 the service was meeting its target of 100% of enuresis referrals to treatment waiting time in 18 weeks.

Are services responsive to people's needs?

- During this same reporting period the service was also meeting its target of 100% for its learning disability referral to treatment waiting times in 18 weeks.

Learning from complaints and concerns

- There was a complaint process in place with a customer services and complaints team within SCC. We saw that complaints raised per month were discussed at the monthly "Clinical Quality and Safety Assurance Group" (CQSAG).
- Between October 2015 to October 2016 there had been 12 complaints raised about the service. Seven of these complaints were upheld and no complaints were referred to the Ombudsman.
- Information about how to make a complaint was made available to service users and those close to them. This information was seen at child health clinics on notices and on the SCC website.
- Where possible, complaints were used to improve service provision. For example, senior managers told us of one complaint, where a couple had separated, and one parent had raised a concern that they had not been invited to their child's team around the child (TAC) meeting since they didn't live with the child. Subsequent to the complaint staff had been reminded to invite both parents to such meetings as appropriate. During our inspection one member of staff gave us an example of care which showed they had invited both parents to a different TAC meeting.

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 did not rate the service. We found:

- There was a clear service vision and strategy in place which staff knew.
- Staff spoke highly of their seniors stating that they were visible, approachable and supportive.
- Staff described a culture within the service whereby the child was paramount, a culture of candour and working together.
- Service users and staff had opportunity to engage with the service on varying levels, and there were numerous examples of innovation, improvement and sustainability.

However:

- Not all staff could access the policy and guidance section of the intranet. There was insufficient oversight of these policies and procedures to ensure that these were reviewed regularly, updated and reflective of the latest guidance

Leadership of this service

- The organisational structure consisted of a cabinet member, children's service accountability board and directorate management team. The service was led by an Interim Chief Nurse and a number of service managers and team leads.
- Staff we spoke with were clear about their roles and showed they understood what they were accountable for.
- There had been a registered manager in post for the service since November 2014.
- We asked 15 members of staff about local leadership. They all told us that leaders were visible, approachable and supportive.
- We observed the names, photos and contact numbers of team managers within the child health clinics we visited. These were presented on notice boards in public areas.

Service vision and strategy

- The service had a clear vision and set of values, with quality and safety as a top priority. The vision was, "All children and families in Suffolk have the right to; be safe; the best education; physical and emotional health and successful preparation for adulthood and employment". There were six core values set: "achieve, support, pride, inspire, respect and empower".
- Ten members of staff we spoke with where familiar with this vision and set of values.
- A recent "Children and Young People's Emotional Wellbeing 2020" transformation plan had been developed. The plan was to transform services and the system that supported emotional wellbeing of all children and young people in East and West Suffolk by 2020. This included health services. There were ten priorities, one of which was developing a single point of access and assessment for support, focusing on the whole family.
- There was a "Children and Young People Business Plan" plan in place dated 2016/2017, which reflected the service's "Family 2020" strategy. This strategy set out the challenges and actions the provider must take as to enable the provider to maintain outcomes for families whilst at the same time facing reduced budgets. The strategy set out principles of the strategy and actions required.

Governance, risk management and quality measurement

- There was governance framework in place with a quality and governance manager in post. We saw documents which mapped out governance arrangements from board level to local teams.
- Monitoring of children and young people's service was overseen by the children's service accountability board, quality engagement and performance board and the directorate management team.
- There were assurance systems and service performance measures, which were reported and monitored with action taken to improve performance. This included a

Are services well-led?

risk register, a "Clinical Quality and Safety Assurance Group" (CQSAG) meetings and a monthly "Children and Young People's Performance Report" which contained a dashboard for each area of the service provision.

- A number of groups reported to the CQSAG including: the performance group, professional development and mentorship group, medicines management group, audit group, practice teacher meetings, "ChatHealth" steering group, clinical policy and guidelines group and the family nurse partnership (FNP) board.
- We reviewed the service's risk register dated March 2017. All entries had a date the risk was added, description of risk, risk rating, mitigating actions, review date and the accountable person or team was captured.
- We checked the CQSAG meeting minutes dated September and October 2016 and March 2017, which established that the risk register was reviewed monthly. Senior managers we spoke with were aware of the risks within the service and the action that was being taken to mitigate risk, in accordance to the risk register in place for example.
- Records showed that regular team meetings took place, for all staff. We checked the last team meeting minutes of three different teams including a health visiting and the children's learning disability nurse team. We found that team meetings were well attended and discussed relevant matters. However we also noted that there was not a standardised agenda for team meetings across the service.
- There were monthly news bulletins which were circulated to all teams within the service.
- Suffolk County Council (SCC) had an internal intranet system whereby staff could access information, policies and guidance. However we were concerned that not all staff could access the policy and guidance section of the intranet and that there was insufficient oversight of policies and procedures to ensure these were regularly reviewed, updated and reflected latest guidance.

Culture within this service

- Staff we spoke with described a culture within the service whereby the child was paramount, of candour and working together. They also told us that they felt well connected to other teams.
- Staff reported the leadership culture made them feel valued and respected. We spoke with fifteen members of staff and they spoke with passion and pride about working within the service.

Public engagement

- Information about how to make a complaint or compliment was made available to service users both in notice format and on the SCC website.
- The public and service users were able to be involved in consultations about service changes. We saw evidence of this on the SCC website.
- There was a parent and carer network of children with additional needs and/or learning disabilities who were a voluntary group involved in the planning of the services for disabled children, young people and their families.

Staff engagement

- School nurses told us that they had been involved in the recent consultation regarding changes to the structure of the school nursing service, and that senior managers had kept them up-to-date with any changes.
- Records showed that regular staff engagement sessions had taken place. These were available at different locations throughout Suffolk.
- An annual staff survey was conducted. We reviewed the results from the latest staff survey 2016. This was a survey of all staff within the children and young people's early help service, and staff beyond the service we inspected however employed by SCC. In 2016 a total of 2,170 children and young people staff were invited to participate of which 54% completed the survey. This was an extensive survey in terms of questions asked and results were variable. For example, 95% of staff said they felt they "make a positive contribution on a day to day basis through my work"; 85% said "I feel a strong sense of belonging to my team", however, only 36% said that the "Directorate Management Team are approachable, listen and respond" and 44% said "I have enough time to do what is expected of me". We have interpreted these results with caution since children and young people's health staff (the service this inspection report relates to) only represented about 10% of all staff, and these survey findings did not reflect what staff told us during our inspection.

Innovation, improvement and sustainability

- The service offered the family nurse partnership (FNP) programme, which was a voluntary service for under 20's who were expecting their first baby and were registered with a general practitioner (GP) in Ipswich. Each service user was allocated a family nurse, who was

Are services well-led?

a qualified health visitor and had completed further training in FNP, who visited them frequently during the antenatal and postnatal period, until the child was two years of age.

- "Family 2020" was a "five year partnership plan to transform the way that families are supported in Suffolk – with three changes to the to the way we [SCC] design and deliver services". These three changes included improving the understanding and anticipating of families' needs, developing early help intervention to target individuals and creating a single point of access manage demand and make best use of system resources.
- The "health visiting, school nursing and family nurse partnership services were subject to an approximate 7% cut in funding over three years commencing April 2017".

The service was taking appropriate action in relation to this by redesigning health visiting and school nurse services and by implementing and actioning a staff recruitment and retention programme.

- In November 2015 the school nursing service introduced a "ChatHealth" service for young people aged 11-19 years. This was a text messaging service to enable young people to confidentially ask for help about a range of issues, or to make an appointment with a school nurse.
- A recent "Children and Young People's Emotional Wellbeing 2020" transformation plan had been developed. The plan was to transform services and the system that supports emotional wellbeing of all children and young people in East and West Suffolk by 2020. There were ten priorities, one of which was developing a single point of access and assessment for support, focusing on the whole family.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established nor operated effectively to ensure compliance with the requirements of this regulation. Pre-employment records were not kept up-to-date as essential data was missing; policies and procedures were not up-to-date and not all staff could access these. Regulation 17 (1) (2) (a) (b)