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

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

Where applicable, we have reported on each core service provided by Nottinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Trust.
## Summary of findings

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for Community Health Services for children, young people and families.</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are Community Health Services for children, young people and families. safe?</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Are Community Health Services for children, young people and families. caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are Community Health Services for children, young people and families. effective?</td>
<td>Good</td>
</tr>
<tr>
<td>Are Community Health Services for children, young people and families. responsive?</td>
<td>Good</td>
</tr>
<tr>
<td>Are Community Health Services for children, young people and families. well-led?</td>
<td>Good</td>
</tr>
</tbody>
</table>
Summary of findings

Contents

Summary of this inspection

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall summary</td>
<td>4</td>
</tr>
<tr>
<td>Background to the service</td>
<td>5</td>
</tr>
<tr>
<td>Our inspection team</td>
<td>5</td>
</tr>
<tr>
<td>Why we carried out this inspection</td>
<td>5</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>5</td>
</tr>
<tr>
<td>What people who use the provider say</td>
<td>6</td>
</tr>
<tr>
<td>Good practice</td>
<td>6</td>
</tr>
<tr>
<td>Areas for improvement</td>
<td>6</td>
</tr>
</tbody>
</table>

Detailed findings from this inspection

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings by our five questions</td>
<td>8</td>
</tr>
<tr>
<td>Action we have told the provider to take</td>
<td>19</td>
</tr>
</tbody>
</table>
Community health services for children, young people and families is part of the Health Partnerships Division of the trust. Services include enuresis clinics, baby clinics, family and early years support, speech and language therapy, health visitors, midwives, and learning and educational advisors.

We found that children and families services were generally safe, but that there was a risk to safety in the Children’s Development Centre at Nottingham City Hospital because medicines were not being properly managed or monitored. There were, however, good arrangements for safeguarding and reporting incidents.

Staff resources were being used appropriately. We saw this had been planned to meet the needs of families in the local area, including vulnerable and minority groups. Staff used best practice guidance and encouraged volunteering to build community capacity, as well as make the service better. We were told by staff that there were some difficulties with information technology systems, but we saw that these issues were being reviewed by the trust.

The service was caring. It focused on the needs of the family and the child, with staff building close, trusting relationships with the people who use the services. We found that there were clear arrangements and staff in place to provide children and their families with emotional support.

People had good access to community services through the children’s centres and in their homes. Families using the service were asked for feedback on the care, treatment and support provided, and the trust also held focus groups to gather feedback on service developments. Staff worked effectively to ensure the multidisciplinary team and other services met people’s needs.

Services were well-led. There was visible senior leadership and staff we spoke with knew the priorities for activity and service developments. There were arrangements in place for regular staff training and supervision.
Background to the service
The Health Partnerships Division of the trust works closely with primary care services to provide community health services for Nottinghamshire and Bassetlaw. The division is a partnership model, with services in Nottinghamshire provided by County Health Partnerships, and services in Bassetlaw provided by Bassetlaw Health Partnerships. We visited community-based teams, three children’s centres, and children’s development centres and outpatient clinics at two locations. Services include enuresis clinics, baby clinics, family and early years support, speech and language therapy, health visitors, midwives, and learning and educational advisors. The trust also contributes to the provision of Sure Start services giving support, guidance, and information for parents or guardians of children at the crawling and toddler stage of a child’s development.

The Paediatric Occupational Therapist (OT) Triage Clinic provides assessment and treatment for children aged 0 to 19 years with conditions that inhibit physical and functional development. These include neurological, neuromuscular, syndromes, orthopaedic and genetic conditions, and children with moderate and severe learning disabilities.

Nottingham City Hospital Children’s Development Centre (CDC) provides specialist advice and support to parents or guardians of children aged 0 to 19 years who have complex health needs and associated physical or learning disabilities, including life limiting conditions. The CDC provides community nursing support for consultant clinics, day care services three days per week, and has eight respite beds available five days per week.

Our inspection team
Our inspection team was led by:

**Chair:** Dr Paul Lelliott, Deputy Chief Inspector Hospitals (Mental Health and Substance Misuse), CQC

**Team Leader:** Jenny Wilkes, Interim Head of Inspection, Care Quality Commission

The team included inspectors, inspection managers, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors, which included school nurses, health visitors and Experts by Experience.

Why we carried out this inspection
We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health services inspection programme.

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

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

We visit the community health services for children, young people and families of Nottinghamshire Healthcare NHS Trust on 29, 30 April and 1 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit,
we held focus groups with a range of staff, including nurses, doctors and therapists, and talked with people who use services, their carers and/or families. We observed how people were being cared for and reviewed their care or treatment records.

What people who use the provider say

People told us that they were very satisfied with the provision of services for children and families. They said that the service being provided in local children’s centres or community settings meant they could access services easily.

Much of the service is provided direct into people’s homes and people told us they developed strong, trusting relationships with the staff providing their care and support. Young parents told us they had been supported very well and given great confidence to develop their personal and parenting skills.

Good practice

The trust had a family nurse partnership team which provided intensive support to teenage mothers before the child was born and for the following 22 months. The system is research based and a well-established programme of support. This meant that very vulnerable young mothers were given support to develop their coping and parenting skills, thereby reducing dependence on other services.

Across all children and family locations we found evidence of good collaborative working and good inter-agency working between trust staff schools and children’s homes.

Care and treatment of children and support for their families, within all services, was empathetic and compassionate. Staff across all services promoted and maintained the dignity of all children, their parents and guardians.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

• The trust must ensure that there is safe medicines management in the Children’s Development Centre at Nottingham City Hospital. There was no local policy for medicines management and there were no pharmacy or departmental audits to check that medicines had been managed appropriately and administered accurately and safely.

Action the provider SHOULD take to improve:

• Ensure that arrangements for work-based training and support for health visitors is in place.
• Improve IT connectivity for staff as many teams reported concerns, especially when working remotely and there was a risk of information being lost.
• Consider the introduction of a competency assessment framework to support the therapy support workers, occupational therapists and physiotherapists at the Children’s Development Centre based at Nottingham City Hospital Campus.
Summary of findings

- Ensure that how services inform parents and guardians on how to raise concerns or complaints is implemented consistently across all services and that all services maintain local complaints register to ensure local learning takes place.

- Ensure that patient feedback questionnaires are readily available at all locations and are identifiable so that the trust can ensure feedback is given to the right service.

- Ensure there are consistent clinical governance arrangements across services, including internal clinical audits and parent or guardian feedback sessions.
The five questions we ask about core services and what we found

Are community health services for children, young people and families safe?

By safe, we mean that people are protected from abuse

Summary of findings
Overall, we found that services were well managed, monitored, and staff were well trained and supported to provide safe services. However, there was a risk to safety in the Children’s Development Centre at Nottingham City Hospital because medicines were not being properly managed or monitored.

There were strong systems in place to monitor and report incidents and concerns. There were also good arrangements to protect children from abuse. All staff we spoke with knew the safeguarding procedures and the systems they would use to make sure that action was taken when needed.

Track record on safety
We found that services were generally safe as children and young people and families were protected from abuse and avoidable harm. Staff in all children and families services teams’ told us that they had attended appropriate level safeguarding training which was kept up to date. All staff were able to describe the reporting procedures they would use if they suspected abuse. Staff were clear about the reporting information system they would use, the lead officer or manager they could discuss issues when needed and the multi-agency safeguarding hub (MASH) they would contact to record concerns.

We saw systems in place which had enabled staff to highlight potential and actual risks. Staff showed us how they had managed care and treatment plans well, escalated concerns and safeguarded children and families in their care.
Learning from incidents and improving safety standards
There had been no recent never events reported within the children and family locations we inspected. All staff we spoke with stated that they were encouraged to report incidents and received direct feedback from their managers or supervisors. Themes from incidents were discussed at staff meetings held weekly or monthly. We saw evidence of how recent incidents had been managed through a root cause analysis which resulted in further training and dissemination of lessons learned. Heads of service told us they attended professional lead meetings to share learning from experiences including incidents. Managers told us they received action points following any case reviews and then ensured learning points were shared with all staff at team meetings.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse
There was a clear safeguarding policy in place. Staff we spoke with in all children’s services teams were able to state who their local safeguarding lead person was in their respective areas. Staff provided examples of when and how they had raised alerts. Staff told us they felt supported by their immediate line managers with safeguarding issues and found the safeguarding team easily accessible and helpful.

Staff had effective supervision of their clinical practice and this included regular safeguarding supervision relevant to their role. Safeguarding supervision was conducted every three months for all staff and more regularly for health visitors and school nurses, who due to their work were involved in child protection cases and serious case reviews. This meant that staff were able to discuss issues openly and appropriate procedures were being followed.

There were effective systems to gather information from other services. There were liaison health visitors based in the accident and emergency department to assess all attendances of children up to aged five to share information with the area health visitors. Information was also shared with school nurse teams about the attendances of children of other ages where self-harm had been involved. There was also good sharing of information with GPs about such issues as safeguarding or a new medical diagnosis of a child which may mean the health visitor could provide extra support. This meant that community teams had good knowledge about injuries or illnesses to enable support of children and families.

The community bases, centres and clinics we visited were fit for purpose and there were effective infection control procedures in place. Medicines, including first aid boxes, were kept secure and handled safely. Equipment was well maintained so that it was safe for use. However at the Children’s Development Centre, based at Nottingham City Hospital, there was a long-term programme of internal improvements replacing fixtures, fittings and redecorating. A member of staff told us the works could be disruptive to care delivery but they had worked around issues. Parents told us they did not mind the disruption as long as their child was safe and happy. In order to reduce the impact on staff and service users the management team had implemented improved cleaning systems and schedules. Building contractors operating within the centre had undergone appropriate police checks.

Systems to ensure safety of medicines were inadequate at the Children’s Development Centre at Nottingham City Hospital. There was a lack of pharmacy support to monitor arrangements. The management team told us there has been no external pharmacy audit for two years and no internal pharmacy audit for nearly a year. There was no local medicines management policy for staff guidance about safe medicines procedures for children and families. This represented a potential risk to patient safety. The trust could not be sure that medicines were being managed appropriately at this location.

Medical cover was informally agreed for some children in respite care. Staff told us that in the event of a child occupying a respite bed in ‘Short Breaks’ and requiring a medical intervention there was no formal agreement for medical staff and GP cover was not available. Staff had to ask medical staff who were providing clinic sessions. We were told by staff there was no service level agreement in place to support this demand and it relied on the capacity and good will of the individual medic to attend when required. Staff told us this meant that there may have been delays in assessments or prescribing appropriate medications for children, as medical staff were balancing clinic demands and sporadic needs of the child in respite.

We found that school nurses had safe systems in place to ensure supplies of vaccinations were kept at appropriately...
cool temperatures when transporting from the refrigerated store at their base and when being used at vaccination clinics on school premises. This meant that vaccinations were stored and transported safely.

Assessing and monitoring safety and risk
We found staffing levels and skills mix supported safe practice in all the areas we inspected. Risk assessments had been completed to ensure staff and patient safety. Staff were clear on the systems in place to monitor and escalate risks. We noted that there were few risks related to children’s services on the trust wide risk register. Due to the demand and capacity of the service, some teams told us that they were stretched at times of acute need. We found that some health visitors considered their caseloads were such that they could not provide the support they would like to as professional practitioners but were focussed on achieving targets, such as for new born assessments and developmental assessments.

We spoke with health visitors, family and early years workers and family nurse partnership staff about working out in people’s homes and the community. All staff confirmed they had clear procedures about lone working to follow which meant the provider had made effective arrangements to protect the safety of staff.

Understanding and management of foreseeable risks
The trust had systems in place to deliver safe care both now and in the future. We saw health visitor staffing levels were being increased as part of the Health Visitor (HV) implementation plan and recruitment was ongoing. There were plans to increase HV numbers from 122 to 132 by 2016. There had been collaboration with commissioners, based on public health reviews of the needs of the population locally, to scale the increase in staff resources.

Some staff told us that staff were not replaced on a temporary basis when there was maternity leave or long-term sick leave. Staff told us they would, by agreement, work longer hours to ensure staff shortages did not compromise children’s care and treatment.

The effectiveness of computers to support their work was a common concern across staff in many locations. Managers told us the trust planned to improve systems using an e-health platform and enable increased interaction with children and young people.
Are community health services for children, young people and families 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 of findings**

The service was effective as staff resources were allocated to meet the needs of families and children. Many services were provided in the people’s homes or children’s centres, which meant that people could easily access services in their local community. Services were directed at particular groups to make sure that children in vulnerable or minority groups were well supported. They were also targeted at key outcomes, such as breastfeeding rates, developmental checks and uptake of vaccinations. We found that different services, including with GPs, social workers and community paediatric services, worked well together. Some staff reported problems with information technology, but we found that the trust had recognised the difficulties and had plans in place to improve the systems.

**Assessment and delivery of care and treatment**

At all children and family locations and teams we found care provided was evidence based and followed recognised and approved national guidance. Staff understood their roles and clinicians worked within their scope of practice in accordance with their professional governing bodies. Health visitor teams ensured that new born children received appropriate assessment and parents received support, and that children received developmental assessment at the expected stages.

We saw robust evidence of multi-disciplinary working to maximise the health and well-being of children and families. We inspected the Paediatric Occupational therapy (OT) Triage Clinic based at Bassetlaw District General Hospital. For example the OT Triage clinic promoted the ‘Funfit’ programme which linked to mainstream schools. OTs worked closely with the school teaching assistants to identify and work with children to improve physical development as part of the Governments ‘Healthy Schools Programme’. One parent told us their child’s balance and core stability had improved since starting the programme and their child was ‘less clumsy and generally happier’.

**Outcomes for people using services**

We found across all children and family locations there were systems in place to measure the quality of care delivered. We saw that not all services maintained a local complaints register to highlight areas of concern.

We saw waiting times in the OT Triage Clinic based at Bassetlaw District General Hospital had been significantly reduced following a review of waiting times from referrals to assessment and action to improve the service. Additional appointments were offered, reducing waiting times from above 15 weeks to below 12 weeks. Waiting times in general across services ranged from between two - nine weeks, which met the trust’s target of 13 weeks or less.

The Children’s Therapy Centre, based at Kings Mill Hospital, introduced extra activities, such as hydrotherapy in the evening and Saturdays, in addition to the child’s planned care and treatment. This was evaluated and due to low uptake classes were reduced to reflect patient demands.

**Staff, equipment and facilities**

There were sufficient suitably trained staff to meet the needs of children and families in all locations we inspected. We found that there were systems and processes in place to identify and plan for children and young people’s safety issues in advance.

We found the trust provided a comprehensive induction programme for all new staff and there was a good uptake of mandatory training and effective appraisal processes for all staff. Competency assessments for staff varied across locations. We found nursing competency assessments were in place demonstrating nurses were competent to carry out specific nursing tasks. However, we saw there was no competency assessment framework to support the therapy support workers, occupational therapists and physiotherapists at the Children’s Development Centre based at Nottingham City Hospital Campus. This meant the trust was reliant on staff personal and professional awareness of maintaining and developing competency.

Management arrangements across teams were generally effective and supportive but some manager’s capacity was stretched as they oversaw a number of different physical
locations. Facilities were fit for purpose and equipment, across the locations we inspected, were in adequate supply and age appropriate to meet children’s needs from 0 to 19 years.

We saw access to outdoor facilities at the Children Therapy Centre at Kings Mill Hospital was limited. For example, there were no wheelchair friendly activities for children to use such as a wheelchair roundabout or swing. Staff told us this concern had been escalated, however there were no plans in place to review this.

Staff told us that IT issues could sometimes affect their efficiency. Concerns about the connectivity and access to IT systems were reported by a number of teams within the children’s services including, the OT Triage Clinic at Bassetlaw District General Hospital and the Children’s Development Centre at Nottingham City Campus Hospital. They cited delays in updating risk assessments and care plans. On occasions staff had not been able to log on to the system for up to four hours. Staff told us they had problems accessing IT when working remotely, which meant in some cases staff had to transcribe information from hard copies to electronic records. IT technical issues were creating delays in updating information and there was a risk of information being lost.

Multi-disciplinary working
Across all children and family locations we found evidence of good collaborative working. We saw there were meetings involving midwives, speech and language therapists, health visitors and school nurses all working together placing the child and family at the centre of care delivery. We saw evidence of good inter-agency working between trust staff and teaching assistants, schools and parents in community settings such as at special schools, mainstream schools and children’s homes.

Staff used the ‘SystmOne’ clinical computer system, which allowed all healthcare professionals access to current information about the care and treatment plan. The system was used to report incidents, share information between professionals and to record care and treatment activity.

We saw communication across disciplines was respectful and sensitive and there was an eagerness to provide effective and individualised care. This was especially evident at the Enuresis Clinic based at The Ashfield Village, where a clinic run by one nurse, was supported as needed by GPs, school nurses and social workers.
Are community health services for children, young people and families caring?

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

Summary of findings
We saw examples of caring and compassionate services that focused on the needs of the family and child. Parents were provided with clear information about the service being offered. Families and children could provide feedback and comments on their care in a variety of ways. They were also given strong emotional support through the teams and through appropriate referrals.

Kindness, dignity and respect
We found the care and treatment of children and support for their families, within all services, was empathetic and compassionate. Staff across all services promoted and maintained the dignity of all children, their parents and guardians. Each child and family’s culture, beliefs and values were taken into account in the planning and delivery of care. Staff ensured confidentiality was maintained when attending to care needs. We found that staff had developed trusting relationships with parents and guardians that focussed on maximising children’s independence.

We found that feedback from children and their families at the services we inspected was very positive. We spoke to parents about the Enuresis Clinic based at Ashfield Health Village and they told us they were generally happy with the service and felt involved and respected.

All parents told us their child had been spoken to with dignity and the consultation was focused on the child. We observed interaction between staff and child in a variety of settings, across all locations, and saw staff demonstrated a caring and sensitive approach. We saw that generally parent’s expectations had been met. One family we spoke with expressed their disappointment at having had three different members of staff at each of their three appointments. They had expected, and would have preferred, to see the same staff to reduce embarrassment and provide continuity.

People using services involvement
We found that staff provided child centred care within all services. Children, their parents and guardians were involved in and were central to, all decisions made about the care and support needed. Overall we found that parents had an understanding of their children’s care and treatment. Parents across all locations told us they felt supported by health care professionals and one parent said, “Staff make me feel like we’re all part of a big family, it gets really hard sometimes but they are always there and make sure I have all the information I need every step of the way”.

We looked at records and observed direct interaction between staff and people who used the service. Risk assessments and care plans were individualised to the child and included parents and guardians wishes relating to care and treatment. We saw some areas provided additional information specific to conditions. For example the Children’s Development Centre at Nottingham City Hospital Campus ran a resource library to provide parents and guardians with literature about their child’s condition and support organisations. Parents told us this service was invaluabale and answered many of their questions.

Emotional support for care and treatment
We found that in most locations staff delivered good emotional support within its children and family services. Parents told us that there was effective communication from staff and that any concerns were addressed quickly and sensitively. We found that each local area had an emotional health team which included a nurse, social worker and counsellor. Many staff said that their service was provided in a family’s home which meant they were able to provide face to face individual support to parents and children and develop trusting relationships. Staff told us that issues of consent and sharing of information between professionals and services were always discussed with parents and children.

We found that children’s centres and health visitors had been involved in developing several projects to support women who may have been subject to domestic violence. This included the Broxtowe Women’s project, and a ‘Freedom’ project, with women attending a course to develop their understanding and awareness of the issues and support available. Staff told us of examples of where they had been able to support women to access refuge facilities for the safety of their family.

Staff from the Children’s Therapy Centre at Kings Mill Hospital told us they provided emotional support they could to parents and guardians but some families were...
signposted for additional support to appropriate volunteer organisations. Staff recognised that some families required more intense intervention and emotional support to help them cope with the reality of caring for a child with long-term severe physical and/or mental health needs. Staff said that on occasions family members could become angry and potentially aggressive. Staff explained they felt they did not always have the expertise or capacity required to devote to parents who deserve more in-depth support and so had to refer to other services.

Staff also told us that they generally felt very well supported and cared for by their managers at all locations. We saw effective systems for staff to have one to one supervision sessions and peer group support was in place.
Are community health services for children, young people and families responsive to people’s needs?

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

**Summary of findings**
Parents and families had good access to services through local clinics and their own homes. Staff in the children’s centres were developing more sessions in community settings where there were travel issues for parents. Families were referred quickly between teams and to other services. Services were targeted at vulnerable groups and feedback about services was gathered. Volunteering was encouraged to involve people who use the service.

**Planning and delivering services**
We found that the geographical location of children and family services across the trust made access throughout the county satisfactory. Although there were 56 local children’s centres across the area staff were also involved in activity to reach out to the local community, for example through providing sessions in local halls or leisure centres. We met with groups of parents who said they felt welcome at the centres and had been encouraged to participate or volunteer to enhance support to local families. Parents or guardians told us in general they had little difficulty travelling to and accessing services when required.

We saw that outreach services were available across all sections of the service. Staff visited children at home, special schools and mainstream schools to ensure care and treatment was delivered with the least amount of disruption to the child’s routine. This meant that services were responsive to the needs of the local population.

**Right care at the right time**
The health visiting team met targets to provide new baby visits and six month checks within expected timescales to promote breastfeeding, monitor development and provide support as needed to mothers.

For some clinic assessments we found that children were expected to be seen within an eight to 12 week timeframe from the point of referral. During a telephone feedback session post inspection parents and guardians told us they waited between two and nine weeks and they were generally satisfied.

We saw staff at the occupational therapy triage clinic, based at Bassetlaw District General Hospital, introduced additional assessment and treatment appointments at times of increased demand to ensure that children were seen as quickly as possible.

Across all services we inspected we saw good use of the interpreting service and language line to improve communication with ethnic groups. This worked particularly well with the Health Visiting Service who planned joint visits with interpreters and provided support literature and clinic information in languages spoken by the local population.

**Care Pathway**
We found referrals between services were timely and well managed with good communication between the disciplines involved. For example, OTs and physiotherapists carried out joint assessments to reduce duplication for the child and their parent or guardian and unnecessary time spent in clinic.

We saw assessments were comprehensive and took into account the child’s spiritual, ethnic and cultural needs and care plans were tailored to meet the child’s individual likes and dislikes.

Referrals to SALT (Speech and Language Therapists), dietician and school nurses were effective placing the child at the forefront of care delivery and promoting a seamless transition between services.

We saw, through good advanced planning practices, that the Children’s Development Centre at Nottingham City Hospital Campus had no waiting list for ‘Short Breaks’ respite. All eight beds were occupied five days per week. Out of hours for medical assessments was provided by Nottingham City Hospital Campus which was based on the same site.

Parents and staff voiced their concerns relating to the length of time local authorities took to implement home adaptations such as walk in showers, ramp access and ceiling tracks for hoists after these had been identified as
being required to meet the needs of patients. This issue caused a great deal of distress to some families. This issue was recognised by the trust board, commissioners and the local authorities and was being looked into.

**Learning from concerns and complaints**

Across all locations generally parents and guardians were very satisfied with the quality of service they received and told us they felt listened to and heard. Staff followed the trust’s complaints policy and provided examples of when they would resolve concerns locally and how to escalate when required.

During our inspection we talked to 35 parents or guardians from various settings and comments included: “The team (Children’s Development Centre) are brilliant, they seem to know everything and have made such a difference to our lives”. “I feel involved (Health Visitors). Staff ask me what I want, meet my needs and point me in the right direction”. “She (Enuresis Nurse) was able to ask my child some really difficult and personal questions about wetting the bed. She was so professional and caring, she was great”.

Staff across all locations reported a visible presence of senior managers and told us they promoted a culture of openness with parents and guardians who were encouraged to express concerns.

However, we found a variance across locations of how services inform parents and guardians on how to raise concerns or complaints. For example patient feedback questionnaires were not readily available at all locations. The questionnaires were generic to the trust and not to the specific service. Staff told us that if the parent forgets to write the name of the service it could get lost. Some services did not display complaints posters in high visibility areas and not all services encouraged parents and guardians to complete feedback questionnaires. Staff told us they simply forgot to ask parents and guardians as clinics were often very busy. We saw some services did not maintain a local complaints register.

The Children’s Development Centre at Nottingham City Hospital Campus sought parent and guardian feedback and analysed their findings. Staff displayed “You said we did” information. Parents had complained that the reception area, including the seating and furniture, looked uninviting. The trust had redecorated the area and replaced the old seating with new.
Are community health services for children, young people and families 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 of findings**

Services were well-led. We saw that there was visible senior leadership and that staff knew the priorities for activity and service developments. There were strong arrangements in place to regularly supervise all staff as it was recognised they may be working with vulnerable children and families.

**Vision and strategy**

Generally, staff across all locations, were aware of the trust’s values, corporate objectives and the ‘Positive’ acronym, which was a key statement of the trust’s values and behaviours.

Within the Children’s Service Development Plan the trust sets out a five year strategy and identifies four key areas for continued improvement including expansion of the health visiting service the redesign of the pathway for children with emotional and mental health needs, development an e-health programme and the redesign of a ‘single door’ access point to reduce duplication.

The services had clear and focussed management at team level and staff told us they felt they had clear direction to develop the services further so the needs of children and families using the service were met.

Staff told us their managers were visible, accessible and approachable and board members had visited the majority of children’s services and had talked with staff, parents and guardians.

**Responsible governance**

Children services across all locations maintained a risk register that then linked to the overall trust governance arrangements, so the Board had oversight of the key risks. Although we found minimal reference to children’s services in the corporate risk register.

We found inconsistencies with clinical governance arrangements between services. For example not all services carried out internal clinical audits or conducted parent or guardian feedback sessions. One manager told us, “I know we give a safe and effective service because I know my staff well and we have received no complaints”. There were very good arrangements to secure feedback from some groups of service users. At children’s centres the service used parent forums to ensure the users of the service had direct involvement in plans or developments of that service.

We saw the Health Visiting Service regularly reviewed parent and guardian feedback and acted swiftly to resolve concerns as part of a multi-disciplinary approach to providing a quality service.

**Leadership and culture**

Staff across all locations said they were generally well supported by the line managers. We saw effective leadership at team level and staff supported with regular supervision, and appraisals. Clinical supervision was well attended across all locations especially for staff involved in child protection cases such as health visitors and school nurses who attended sessions at three monthly intervals.

Some staff told us they felt supported with professional development. Access to University modules specific to job roles and access to post graduate diplomas was encouraged to promote ongoing training and development of the service. There was a variance across services relating to how much funding and protected time was provided to access courses. Some staff told us it was a balance between meeting the demands of the service and current capacity and not all requests had been granted, particularly when services experienced long term absences due to maternity leave or sickness. We found that some health visitors, who were newly appointed, had not been supported as comprehensively as they expected due to reduced availability of mentors during staff shortages. The team of health visitors was being increased which meant there would be increased demand for mentorship support.

**Engagement**

We found a variance across locations of how services obtained parent or guardian feedback. For example, questionnaires were not always displayed in a prominent location. The questionnaires were generic to the trust and not to the specific service. Staff told us, if the parent forgets to write the name of the service, it could get lost.
We saw there was inconsistency across services relating to PALS (Patient and Liaison Service) information. Some services displayed information in communal areas and other services displayed one set of leaflets at the reception desk which could be easily missed.

**Performance Improvement**

All services had appropriate monitoring, reporting and lessons learned built into the long-term objectives for service improvements. We saw evidence of additional staff training, shadowing and monitoring for staff involved.

The problems of IT support in community activity, reported by staff at many of the locations, had been escalated to trust board level. We saw plans had been implemented, in stages, to tackle the problem. Health visiting teams were having improvements made to their mobile working and plans were in place to improve facilities and access at designated locations. The intention was to improve the efficiency of communication, recording of activity and accessibility for parents and guardians.

The Children’s Development Centre at Nottingham City Hospital Campus had been visited by trust board members to review disruption to the service cause by IT connectivity and ongoing internal work. We were told by senior managers issues were considered a priority for a speedy resolve to minimise further service disruption.
Compliance actions

Action we have told the provider to take

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>The service did not protect patients against the risks of inappropriate or unsafe care and treatment, by means of implementing effective operation of systems such as the provision of a local medicines management policy specific to the service. Regularly assessing, monitoring and auditing the quality of medicines management within the service.</td>
</tr>
<tr>
<td></td>
<td>Regulation 10 (1) (a) (2) (c) (ii)</td>
</tr>
</tbody>
</table>