

South Tees Hospitals NHS Foundation Trust

RTR

Community health services for children, young people and families

Quality Report

CQC Registered Location

The James Cook University Hospital

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RTRAT

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

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

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

Summary of findings

Ratings

Overall rating for Community health services for children, young people and families

Good



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

Good



Are Community health services for children, young people and families effective?

Good



Are Community health services for children, young people and families caring?

Good



Are Community health services for children, young people and families responsive?

Good



Are Community health services for children, young people and families well-led?

Good



Summary of findings

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Summary of findings

Overall summary

Community health services for children, young people and families at this trust had well-established systems for incident reporting and analysis using the Datix healthcare software system. Staff told us, and we saw evidence in team meeting notes, that incidents were analysed at a local level and learning was discussed within teams. Staff understood their responsibilities to raise concerns, and report incidents and near misses.

There were effective arrangements in place to manage and monitor the prevention and control of infection, and safeguard people from abuse.

Outcome monitoring for children, young people and their families using the service varied. Staff assessed and delivered treatment in line with current legislation, standards and recognised evidence-based guidance. There was evidence that performance was reviewed and actions were in place to improve outcomes.

The service followed local policies and national guidance to achieve the best outcomes for young people using the service. The service was actively engaged with regional and national networks. Staff were trained and competent to give specialist advice and treatments.

Health promotion work and advice was given to young people to assist them in making safe choices and keeping themselves safe.

Children, young people and their carers said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Information was provided to help children and young people understand the care available to them.

Children, young people and their carers were treated with kindness and respect, ensuring that confidentiality was maintained.

Children, young people and their carers felt included in decision-making. They were listened to and able to express their opinions, which they felt were taken into account.

People were able to access care and treatment close to home in local clinics and treatment centres.

Services were flexible and worked across professional and organisational boundaries.

There were systems within all teams for learning from experiences, concerns and complaints.

Staff knew the vision, strategy and objectives for the trust. There were service and team meetings which included items on risk, safety and quality. There were systems for recording and managing risks; managers were approachable and visible.

Staff and teams worked collaboratively to deliver quality care. The services sought out and acted on feedback from patients.

Summary of findings

Background to the service

Community health services for children, young people and families were provided across Middlesbrough, Redcar and Cleveland by health visitors, school nurses and the looked after children team.

The trust provided a health visiting service to Middlesbrough and Redcar and Cleveland. The service was for children aged under five years and aimed to protect and promote the health and wellbeing of children in the early years in line with the Healthy Child Programme.

The trust provided school nursing services in Middlesbrough and Redcar and Cleveland. School nurses assessed child and family health needs in line with the Healthy Child Programme.

The looked after children team was commissioned by South Tees clinical commissioning group to provide initial health assessments and reviews for children looked after by either Middlesbrough or Redcar and Cleveland local authorities who were placed with carers within Teesside.

During the inspection we spoke with 61 members of staff working within these teams. We spoke with staff, including managers, health visitors, school nurses, community nurses, therapists, support staff and administrative staff.

We observed care and treatment during 11 visits and appointments. We spoke with 19 children or their carers and looked at 16 care records. Prior to and following our inspection, we reviewed performance information about, and from, the trust.

The health of people in Middlesbrough is generally worse than the England average. Deprivation is higher than average and about 9,700 children live in poverty.

Breastfeeding initiation and prevalence rates reflect the levels of deprivation in the Borough as being ranked as one of the five lowest in England.

11.7% the population is estimated to be from the Black and Minority Ethnic (BME) community compared to the regional average of 8.2% making Middlesbrough one of the most diverse places to live in the north east.

The health of people in Redcar and Cleveland is mixed compared with the average for England. Deprivation is higher than average and about 6,700 children live in poverty.

Breastfeeding initiation and prevalence rates reflect the levels of deprivation in the Borough as being ranked as one of the five lowest in England.

Children and young people under the age of 20 years make up 26.0% of the population of Middlesbrough. 21.0% of school children are from a minority ethnic group.

The health and wellbeing of children in Middlesbrough is generally worse than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 34.3% of children aged less than 16 years living in poverty. The rate of family homelessness is better than the England average.

Children in Middlesbrough have worse than average levels of obesity: 11.9% of children aged 4-5 years and 22.9% of children aged 10-11 years are classified as obese.

In 2012/13, children were admitted for mental health conditions at a similar rate to that in England as a whole. The rate of inpatient admissions during the same period because of self-harm was higher than the England average.

There were 360 children in care at 31 March 2013, which is a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared to the England average for this group of children.

Our inspection team

Our inspection team was led by:

Summary of findings

Chair: Sandra Christie, Director of Nursing, Wirral Community NHS Trust **Team Leader:** Julie Walton, Head of Hospital Inspection, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists, including a health visitor, school nurse and children's therapist.

Why we carried out this inspection

South Tees Hospitals NHS Foundation Trust was inspected as part of the scheduled programme of

comprehensive inspections. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

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 inspected the community health services for children, young people and families across the trust's locations.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 9 to 12 December 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We

observed how people were being cared for and talked with carers and/or family members and reviewed patients' care or treatment records. We met with service users and carers, who shared their views and experiences of the core service.

We held a listening event on 2 December 2014 in Middlesbrough to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

During our inspection we spoke with 19 families and children who used the services. All the people we spoke with were happy with the care they received. People spoke highly of the staff and their caring and supportive approach.

What people who use the provider say

Children, young people and their carers said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Good practice

- A Baby Stars programme was in place to promote the social, emotional and physical development of infants.
- The school nursing service held weekly drop-ins for children and young people.
- There was a breastfeeding group with trained peer supporters and facilitators
- There were good transition arrangements for young people transferring to adult services.

Summary of findings

- The services enabled good accessibility for children and young people by offering different clinics and opening times.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The service should ensure staff are aware of their responsibility around the Duty of Candour.
- The trust should review how they manage and measure caseloads for health visitors and school nurses.
- Continue to review compliance with the Family Nurse Partnership (FNP) targets.

South Tees Hospitals NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The services had well-established systems for incident reporting and analysis using the Datix healthcare software system. Staff told us, and we saw evidence in team meeting notes, that incidents were analysed at a local level and learning was discussed within teams. Staff understood their responsibilities to raise concerns and report incidents and near misses.

There were effective arrangements in place to manage and monitor the prevention and control of infection, and safeguard people from abuse.

Incidents, reporting and learning

- There was a trust-wide electronic incident reporting process, which all staff we spoke to were aware of. Staff told us they felt confident in reporting incidents and had seen action taken to reduce the risk of incidents recurring.
- Minutes from team meetings and action plans showed that learning from incidents took place within teams. Staff were able to describe where prompt action had been taken or lessons had been learned to improve practice. For example, there had been two incidents where data was put in the wrong patient file. It had been identified that administrative staff needed to be careful when scanning documents to ensure they were in the correct patient files. An action plan had been developed and implemented to improve document scanning and to ensure that information was saved in the correct files.

- All the staff we spoke with were able to explain with confidence how they would identify and report incidents using the electronic reporting systems.

Cleanliness, infection control and hygiene

- There were policies and procedures for infection prevention and control. Staff reported they had received infection control training and information.
- We found the clinics we visited were clean, tidy and in a good state of repair. Staff were seen to be adhering to the 'bare below the elbows' policy for best practice hygiene. Records showed staff were 100% compliant with infection prevention training for hand hygiene and infection control.
- All staff had access to personal protective equipment and hand gel to take with them on visits. Staff confirmed that there was always enough stock available.
- There was a policy for staff in therapy clinics to ensure that equipment was cleaned before and after use and we saw signed information sheets to confirm this.

Maintenance of environment and equipment

- We found equipment such as weighing scales were maintained and calibrated in line with the manufacturer's guidance.
- We saw that the environment at the West Acklam Centre was suitable for the children and young people using the paediatric therapies service. It was bright, clean and decorated in a manner appropriate to the age of the children using the service. The environment had been redesigned with input from paediatric therapy services and included an outside sensory play area for children.
- Clinics had access to hoists and there was good disability access to clinics.
- Staff told us that they had enough equipment to deliver care and they had no problems ordering equipment. The paediatric therapy team reported they had good access to equipment for children using the service, and most items were readily available and delivered promptly.
- Equipment was portable appliance tested (PAT) and these were in date.

Medicines management

- Medicines, including first aid boxes, were kept secure and handled safely. Staff were aware of the trust's protocols for handling medicines so that the risks to people were minimised.

- There were appropriate systems to protect patients against the risks associated with the unsafe use and management of medicines. Systems were in place to reflect on the findings of learning from adverse events, incidents and near misses relating to medicines to reduce the risk of them being repeated.
- Fridge temperatures were monitored daily. Staff had a telephone number to call if they wanted to raise any concerns to ensure that temperatures were monitored appropriately to maintain medicines' effectiveness. Vaccines were stored appropriately, rotated by date and monitored.

Duty of Candour

- Senior managers were aware of the Duty of Candour regulations which came in to effect in November 2014. None of the clinical staff we spoke with were aware of the duty. However, clinical staff were familiar with the principles of 'being open' (National Patient Safety Agency, 2009) that promoted acknowledging, apologising, investigating and explaining when things went wrong.

Safeguarding

- Child protection policies and systems were reviewed. These included a process for following up children who missed appointments or attendances at the emergency department and there was a system for highlighting children where there were safeguarding concerns.
- The trust had a safeguarding team who were able to give members of staff advice, training and planned supervision. There were also drop-in sessions for staff with the local safeguarding board.
- We looked at the mandatory training figures for the service which showed that 100% of staff had completed level 3 safeguarding training. We saw local information which corroborated this.
- Staff we spoke with demonstrated good knowledge and awareness of safeguarding processes. They were able to describe the processes that were in place and knew how to escalate concerns. Staff told us that they had good communication with social workers.
- There was evidence of good liaison and communication between the GP and health visitor. The health visitor communicated directly with the GP – both face-to-face and by using the electronic patient record system.

- The services were aware of how to recognise signs of child sexual exploitation and had robust systems to raise any concerns. The services had access to drop-in sessions with the Chief Commissioner of the police service.
- There was an alerting system for missing children and links with the Multi-Agency Public Protection Arrangement (MAPPA), the authorities in place to ensure the successful management of violent and sexual offenders and others who pose a risk of harm to the public. There was a formal process for notifying professionals of missing children, perpetrators or people who might pose a risk.
- The trust had not been involved in any serious case reviews in 2013/14. However, work had commenced on two serious case reviews in safeguarding children for 2014/15.
- The trust had systems for identifying and tracking the number of looked after children in and out of the Middlesbrough and Redcar and Cleveland areas.
- The trust was commissioned to provide review health assessments (RHAs) for Middlesbrough or Redcar and Cleveland children who were placed within any of the four Tees boroughs. For children who were placed in Middlesbrough, there were occasions when there had been problems carrying out their RHA because, for example, a child may be placed in Middlesbrough but attended school out of the South Tees area.

Records systems and management

- Staff used an electronic system for recording patient information which they told us was secure and easy to navigate. Some services also used paper records, for example, paediatric therapy services. We saw that notes and files were held securely.
- Staff were able to put markers on the healthcare record to alert other staff to certain information –

for example, children who were subject to a child protection plan.

- Audits of the quality of record-keeping were performed across the services and any concerns identified were actioned for improvement.

Lone and remote working

- A lone working policy was in place and staff told us of the trust's protocols for arranging and carrying out home visits, including maintaining staff safety.
- Staff followed the lone working policy. The computerised record system had an alert system so staff were aware of any potential risks when carrying out visits. Staff told us of the trust's protocols for arranging, and carrying out home visits.
- There were systems in place to promote the safety of staff when working alone. Staff told us they operated a joint working system for high-risk activities. We saw that there were reporting systems to ensure that the whereabouts of staff were known. Staff were also provided with mobile phones.

Assessing and responding to patient risk

- Individual teams demonstrated ways they assessed and responded to risk in order to provide a safe service for children, young people and their families.
- There was a domestic abuse pathway and criteria for referrals into the Multi-Agency Risk Assessment Conference (MARAC), part of a coordinated community response to domestic abuse.

Staffing levels and caseload

- In 2011, the Department of Health's health visitor implementation plan identified the government's commitment to increase the number of health visitor's nationally by 4,200 by March 2015, supported by the government's Call to Action initiative to expand and strengthen health visiting services. The trust was on target to reach the health visitor numbers identified.
- Within South Tees Hospitals NHS Foundation Trust, health visiting teams consisted of health visitors supported by community nursery nurses and administration staff. Health visitors had overall responsibility for the caseloads.
- Managers and staff were unclear about caseload numbers. For health visiting, the caseloads varied in size. Generally health visitors had a caseload of 300, but in the more deprived areas the caseload was 200. This was in accordance with the parameters set in national guidance.
- In 2004, the Department of Health's white paper, Choosing health: making healthy choices easier, committed to the provision of "at least one full-time, year round, qualified school nurse for each secondary school and its cluster of primary schools" (school

pyramids).The Community Practitioners and Health Visitors Association (2013) further recommended there should be one full-time public health qualified school nurse for every secondary school and its cluster of primaries, with additional qualified school nurses or community staff nurses according to health need.

- School nursing teams consisted of school nurses, registered nurses and assistant practitioners.
- School nurses did not have a cluster of schools, but each school had a named school nurse attached to it.

Mandatory training

- Managers of services received monthly reports for mandatory training and administrative staff booked staff on training.

- Mandatory training was provided with a mixture of classroom-based and online training.
- 95% of staff had completed their mandatory training,

Managing anticipated risks

- The head of service explained that there were no recorded anticipated risks and all current risks were being actively managed. We talked with a number of staff who told us they felt listened to when they reported concerns that may become a risk.
- Services had plans in place to manage and mitigate anticipated risks, including changes in demand, disruptions to facilities or incidents such as bad weather.

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

Outcome monitoring varied for children, young people and their families using the service. Staff assessed and delivered treatment in line with current legislation, standards and recognised evidence-based guidance. There was evidence that performance was reviewed and actions were in place to improve outcomes.

The service followed local policies and national guidance to achieve the best outcomes for young people using the service. The service was actively engaged with regional and national networks. Staff were trained and competent to give specialist advice and treatments.

Health promotion work and advice was given to young people to assist them in making safe choices and keeping themselves safe.

Evidence-based care and treatment

- All health visitors, school nurses and staff nurses we spoke with were aware of the guidelines relevant to their sphere of practice and reported that they were supported to practice to the standards identified. For example, the Healthy Child Programme (Department of Health 2009), an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices.
- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence-based guidance. For example, the trust had a family nurse partnership (FNP) team. The FNP was a voluntary health visiting programme for first-time mothers, underpinned by internationally recognised, evidence-based guidelines.
- The FNP used a psychoeducational approach and provided ongoing, intensive support to young, first-time mothers and their babies (and fathers and other family members, if mothers wanted them to take part). Structured home visits were delivered by highly trained nurses, starting in early pregnancy and continuing until the child's second birthday.

- Staff followed best practice guidelines and appropriate care pathways and ensured that the best care and treatment was available for each young person.

Nutrition and hydration

- Staff demonstrated a good understanding of individual children's needs and care plans were in place to minimise risks from poor dietary intake as required. The health visiting teams demonstrated robust monitoring of outcomes for children.
- The trust had received United Nations Children's Fund (UNICEF) Baby Friendly Initiative accreditation level 3.
- Health visitors promoted and audited the number of breastfed babies in the area. Information from the UNICEF Baby Friendly Initiative showed that 17.6% of mothers were fully breastfeeding at six weeks, with 6.6% of mothers partially breastfeeding. Figures showed that 75.1% of mothers were artificially feeding babies at six weeks. The service were using a range of initiatives to improve breastfeeding rates which included breastfeeding champions and engagement with local schools.
- The service ran a several weekly breastfeeding group and also provided support using social media.
- We found that 91% of children and young people had been measured for weight and height in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight children and obesity levels within primary schools.
- School nurses and health visitors offered support in accordance with the National Health Visiting service specification to parents and carers whose children's weight fell outside the expected body mass index (BMI) range – for example, referring families to specialist services such as a dietician.

Approach to monitoring quality and people's outcomes

- There was evidence of national and local guidance being discussed and reviewed at team meetings. Clinical care pathways were developed across the service for a variety of conditions using the National Institute for Health and Care Excellence (NICE) guidance.

Are services effective?

- Patients' needs were assessed before care and treatment started and we saw comprehensive needs assessment and care planning. This meant that children and young adults received care and treatment appropriate to their needs. The service monitored the outcomes of interventions. The continuing care team provided effective, complex nursing care packages for children at home and at school. They told us that requests for changes to the existing package of care were processed quickly and effectively so that the changing needs of the children were met appropriately.
- The target for FNP immunisation was 100%. In April, May and June they achieved 90% and in July and August 2014 they achieved 100%.
- Health visitors had a Commissioning for Quality and Innovation (CQUIN) framework which included antenatal visits, referrals to health visitor service, patient experience and 'Transfer Out.' A transfer out is number of children where the health records were transferred to the health visitor service in the new area within 2 weeks of notification.
- Women should have a face to face visit once their pregnancy reaches 28 weeks. The service was given a target of reaching 100% by quarter 4 of 2013/14. The service had achieved 41% in quarter 1 (April- June), 50% in quarter 2 (July – September) and 69% in quarter 3 (October – December).
- All urgent referrals to health visitors received a same day or next working day response to the referral.
- All referrals received a response within five working days.
- All babies of FNP clients received up-to-date immunisations at six months of age.
- The FNP had 64 programmed visits (14 in pregnancy, 28 during infancy, and 22 during toddlerhood). All clients should receive 80% of their expected visits during pregnancy. However, only 60% of FNP clients reached this figure. The FNP service had reviewed compliance with this target. The FNP continued to endeavour to complete all due visits within given timescales, however, identified issues such as clients' frequent house moves meant that this target was not being met.
- Services completed local audits. For example, safe and secure handling of medications in special schools audit, school nursing audit and record-keeping checks. The

audits showed good compliance and action plans included an ongoing audit of two records at each staff development review (SDR) to further improve record-keeping.

- We saw there was a teenage pregnancy action plan. This had been reviewed by a multi-agency group which included a specialist nurse for looked after children and children who were leaving local authority care.
- There was a wheelchair skills training scheme that had some very positive outcomes for children in developing manoeuvring skills. Young people also increased their awareness of personal safety by using their senses to identify hazards when near roads and discussed how to keep themselves safe in their wheelchairs.
- We found that 91% of children and young people had received an immunisation for Human papillomavirus (HPV).

Competent staff

- All newly qualified staff were offered a preceptorship period of practical experience and training during which time they will be supported to develop their confidence and skills as a professional.
- New staff received a comprehensive induction, and effective appraisal processes and clinical supervision arrangements were in place. Staff told us there was good access to and attendance at mandatory training for the majority of teams in the service. More than 95% of staff had had an appraisal.
- Health visitors and school nurses received a minimum of three-monthly safeguarding supervisions of their work with their most vulnerable babies and children. Safeguarding supervision was provided by colleagues with expert knowledge of child protection to minimise risk.
- Staff told us that a range of developmental training was available and staff had been supported by the trust with their continuing professional development. For example, school nurses had access to training for treating Chlamydia and anaphylaxis, and in smoking cessation and the Solihull Programme.

Multidisciplinary working and coordination of care pathways

- Within all services there was an emphasis on interagency working and this helped to signpost individuals to services more effectively, both within the

Are services effective?

trust and external to it. For example, staff reported good access to the Child and Adolescent Mental Health Services (CAMHS) provided by a neighbouring trust and good links with the service for advice and support for children experiencing mental health issues.

- This cross-agency working ensured that practitioners were aware of other services that were available to their patients and so could refer them to therapies, education support and local support groups run by other agencies. For example, school nursing worked with the police, social services and education when working with vulnerable children at risk of exploitation.

Availability of information

- Health promotion information was available in all clinics in child-friendly language.
- When patients were due to move between services, their needs were assessed early with the involvement of all necessary staff, teams and services. For example, children with complex needs who transferred into adult services were given a central contact for adult services and the transition planning started when the child was 14 years old.
- Patients' discharge or transition plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes. People were discharged at an appropriate time and when all necessary care arrangements were in place.
- GPs had a named health visitor who saw the practice on a weekly basis.

Consent

- The health visiting and school nursing services asked parents and carers to opt out of the National Child Measurement Programme if they did not wish their child to be weighed and measured. Health visiting and school nursing services used an opt-in approach for vision and hearing monitoring and asked parents/carers to agree to this.
- Services took the voice of the child into consideration when gaining consent.
- School nursing recognised that obtaining consent could be difficult with young people. They used various methods to address this such as contacting young people in school, sending text messages and offering home visits.
- We were told that staff followed the Fraser guidelines to assess the maturity and competency of children to make decisions and consent to treatment.
- In the case where children were not able to give consent, parental consent was sought and, depending on the treatment planned, was either given verbally or in writing.
- The neonatal service looked at non-verbal communication of the baby when reviewing consent and assessing best interests. For example, they looked at non-verbal information such as pupil dilation when providing care.

Are services caring?

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

Summary

Children, young people and their carers said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Information was provided to help children and young people understand the care available to them.

Children, young people and their carers were treated with kindness and respect ensuring that confidentiality was maintained.

Children, young people and their carers felt included in decision-making. They were listened to and able to express their opinions, which they felt were taken into account.

Compassionate care

- All the staff we spoke with were passionate about providing good quality, person-centred care. Staff were clear about the importance of engaging with families in order to understand their situation and the support they required. We saw that staff provided patient-centred care. Staff encouraged the children and young people to make their own decisions.
- During our inspection we spoke with 19 families and children who used the service. All the people we spoke with were happy with the service they received. People spoke highly of the staff and their caring and supportive approach.

Dignity and respect

- Staff were able to tell us how they would maintain dignity and privacy for children in different settings. They gave us many examples of their use of non-verbal communication to aid in their assessment of children's immediate needs, including pain, anxiety and emotional distress.

Patient understanding and involvement

- We found that all staff were focused on the needs of the children and young people and actively sought to minimise risks to them. Staff told us how hearing the voice of children and young people was fully reflected in the way care was planned and delivered. Feedback and comments from parents was positive and confirmed that their views were sought at all times.

Emotional support

- Children, young people and their families received support to cope emotionally with their treatment and care. All staff we spoke with were focused on children and families and had good links with the local child and adolescent mental health services (CAMHS) for emotional and mental health support.
- Antenatal home appointments from health visitors ensured relationship-building and support prior to the birth of a child.
- The service provided a drop-in centre and support for parents and children about enuresis (bedwetting), including self-help packs where relevant.

Promotion of self-care

- When possible, children and their families were supported to manage their own treatment and care needs. Goals were discussed and agreed and families were given advice and guidance about how they could progress with treatment alone.
- The school nursing team had developed a website so children, young people and parents could find out about the support available from the school nursing service, and seek information about emotional wellbeing, alcohol and drugs, dealing with school pressures and support for young carers.

Are services responsive to people's needs?

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

Summary

People were able to access care and treatment close to home in local clinics and treatment centres.

Services were flexible and worked across professional and organisational boundaries.

There were systems within all teams for learning from experiences, concerns and complaints.

Service planning and delivery to meet the needs of different people

- The staff we spoke with had a good understanding of the population who used the service and were all able to explain the needs of the people they cared for.
- We found that access to services was good, offering different clinics and opening times, tailored to meet children's individual needs, at the times and in the places to best suit their needs. The children's community nursing teams provided direct nursing care to children and young people in their own homes. Services included wound care and dressings, oxygen therapy, care for complex health needs, palliative and terminal nursing care and chronic disease management.

Meeting the needs of people in vulnerable services

- The service had access to interpreting services for people whose first language was not English.
- We found that all staff were focused on the needs of the children and young people. Staff told us how the voices of children and young people were fully reflected in the way care was planned and delivered. We looked at four records and found information about the voice of the child was documented.
- The clinics we visited were well-maintained and decorated in a suitable manner to meet children's needs. Clinics were decorated with brightly coloured posters and information leaflets were clearly displayed.

Equality and diversity

- The trust recently made equality and diversity training mandatory for all staff. This incorporated aspects of dignity at work and 95% of staff had completed dignity at work—valuing equality and diversity training.

- The trust had run a campaign encouraging staff to sign up to become 'personal, fair and diverse' champions within their own areas of work.
- Services were planned, delivered and coordinated to take account of people with complex needs.
- Reasonable adjustments were made so that disabled people could access and use services on an equal basis. For example, the sensory play area used by paediatric therapy staff included play equipment suitable for children who had visual impairments.
- Buildings were accessible and adhered to the Disability Discrimination Act 1995.

Access to the right care at the right time

- We found that all children's services delivered good, safe care coordination. This was generally supported in all areas we inspected where we found that care arrangements met the needs of children and their parents. We found effective communication between community multidisciplinary teams and partner organisations to focus care and treatment on the needs of children who used the service.
- Within children services there were examples of clinics being run at differing times and locations and home visits being timed to minimise disruption, including joint visits where this was appropriate. For example, school nursing teams ran weekly drop-in sessions in school and at local clinics for children who attended a faith school. The service also provided smoking cessation clinics after school.
- The service had reviewed support for new-born infants and their families. The service had open access clinics and drop-in sessions and they also attend Bliss support group meetings. (Bliss is a charity concerned with the care of premature and sick babies.)
- School nurses were trained to level 2 for dealing with self-harm and provided voluntary support to children and young people.
- In the five-month period of April to August 2014, 61% of clients were enrolled on the FNP programme before 16-weeks gestation.
- The service met the 18-week referral-to-treatment times for therapies and the child development service. Follow-up meetings were arranged at initial appointments.

Are services responsive to people's needs?

- School nurses provided in-school health promotion sessions, such as information sessions on puberty for year 6 children.
- Within children and family services we saw examples of clinics being run at differing times and locations and home visits being timed to minimise disruption, including joint visits where this was appropriate.

Discharge, referral and transition arrangements

- Health visiting teams provided a service to children from 0–4 years at which stage children would then move to the school nursing teams from 4–19 years. From speaking with staff it was clear that they were committed to providing a good service with a smooth transition between teams.
- We reviewed information which detailed the arrangements for patient handover between health visitors and school nurses. Where children had additional needs (on universal plus or universal partnership plus of the Healthy Child Programme) a face-to-face handover between staff was arranged. For children on the universal part of the Healthy Child Programme, their electronic record was shared from the health visitor to the school nurse so the school nurse was aware of the child's health history.
- There were arrangements for transferring school nursing records when a child moved out of an area to a new school nursing service.
- All children had their health records transferred to the health visitor service in the new area within two weeks of notification.

- There were transition arrangements into adult services for children with complex needs; these included a named adult professional who would act as the central contact for families during the transfer.
- Staff explained that transition planning commenced at around 14 years of age. This meant plans were initiated and developed to make the transition from children to adult services smooth and seamless.
- There were arrangements in the Looked after children team for children leaving care. Health Passports (containing key information about a person's behaviours and likes and dislikes) had been developed by and for young people leaving care. Training on transitions was included in the annual training programme for foster carers.

Complaints handling (for this service) and learning from feedback

- The community health services for children, young people and families followed the trust's NHS complaints processes. There were complaints leaflets available within the health centres we visited. Staff told us they knew how to manage complaints locally and how to escalate where appropriate.
- We saw evidence of learning and sharing feedback. For example, a joint meeting for health visitors and school nurses discussed a complaint that was resolved locally and confirmed that the service felt it would be useful to share as lessons learned.

Are services well-led?

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

Summary

Staff knew the vision, strategy and objectives for the trust.

There were service and team meetings which included items on risk, safety and quality.

There were systems for recording and managing risks.

Managers were approachable and visible.

Staff and teams worked collaboratively to deliver quality care.

The services sought out and acted on feedback from patients.

Vision and strategy for this service

- There was a children and young people's strategy which was aligned to the trust strategy and vision. The strategy included core values for: quality of care and patient safety; organisational capability; partnerships and engagement; and business sustainability. The strategy was linked to objectives which put children and young people at the centre of service delivery, and promoted continual improvements.
- The health visiting service was on course to ensure that the local population's needs were met in line with the health visitor implementation plan monitored by NHS England. Staff demonstrated awareness of the plan and its aim to expand and develop the service and they knew about the national specifications for health visiting.

Governance, risk management and quality measurement

- There were systems for identifying and investigating safety incidents and an emphasis in the organisation to reduce harm. We saw consistent systems for safeguarding practices, and awareness of appropriate escalation processes for those working alone in the community who may observe safeguarding concerns.
- There was appropriate monitoring, reporting and learning from incidents. We saw clear and effective management across the teams in the service.

- The directorate had a women and children governance lead whose role was to monitor performance and provide reports every quarter to be shared with service managers.

Leadership of this service

- Staff reported that they received good support from their direct line managers and spoke positively about the leadership from senior managers. All staff stated they felt managers were approachable, listened to and acted on what staff said.
- Managers at service level in clinics and community teams were visible. Managers and staff felt that the senior leadership team and board members were visible. Staff reported a positive culture in the service.
- Processes were in place to support frontline staff via supervision, appraisals and ongoing training and development. Information from the board and seniors managers was disseminated to staff via regular email messages and team meetings.

Fit and proper person requirement

- Managers and staff reported that recruitment checks were in place and undertaken.

Culture within this service

- We found a culture of openness among all the staff and teams we met. Staff spoke positively about the services they provided to children and young people. We observed staff working well together and there were positive relationships with other multi-agency partners such as children's centres and schools.
- Staff morale was generally positive as represented by the staff survey. Staff told us the trust's ongoing negotiations with commissioners about the type of school nursing services to be delivered in the future was not affecting their day-to-day work and that they had a high degree of job satisfaction.
- We observed that staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of community health services.

Are services well-led?

Public and staff engagement

- Staff felt involved in the development of the service.
- School nurses collected information from children and young people who had had immunisations. We looked at the feedback from a year 10 DTP (diphtheria and whooping cough) and MenC (meningitis and septicaemia) immunisation session. Young people are offered vaccinations as part of national childhood vaccination programme. The feedback included that 95% of children reported they were made to feel relaxed during the session. However, 7% of children did not feel they had been given information about the possible side effects. In response, the school nursing service had developed a presentation about the possible side effects of the immunisations and had presented it at school assemblies.
- The FNP clients were asked for feedback about the programme by the supervisor at joint home visits. The service had only just started to collect this information and it had not been analysed. The service planned that the feedback would be shared at future meetings.
- At the end of observed health visit, parents completed an evaluation of the visit as part of the school nurse process for gathering information about the visit. The information feedback was very positive.

Innovation, improvement and sustainability

- The trust's paediatric physiotherapy team had been involved in the development of therapy-based design of the clinical areas at the West Acklam Centre.
- The paediatric physiotherapy team worked in partnership with Whizz-Kidz (the charity for disabled children) to provide a wheelchair skills training scheme. This scheme had positive outcomes for children and young people in developing wheelchair manoeuvring skills.
- School nurses had developed a business card that was given to all children at an immunisation session. The business card provided contact details for the school nurse and the local health drop in sessions. Young people could contact the school nurse if they needed advice and information, for example about keeping healthy, smoking, emotional health and immunisations.
- School nurses had also developed a branded school nursing website. The website included information about school nursing services, for example details of health drop in sessions, accessing services for young carers and, information on vaccinations. The Health Zone Website offered confidential and accessible health advice and support for young people aged 11 to 16 years old.
- A Baby Stars programme was available for new and experienced parents to help them understand their baby's behaviour. The programme was based on the Neonatal Behavioural Assessment Scale (NBAS).
- Community nurses who worked with children with complex needs had won a Nightingale Award for Excellence in Nursing for their services.