

## East Sussex Healthcare NHS Trust

RXC

# Community health services for children, young people and families

## Quality Report

**CQC Registered Location**

Bexhill Hospital

Uckfield Community Hospital

Tel: 01424 755255

Website: <http://www.esht.nhs.uk/>

**CQC Location ID**

RXC03

RXC18

Date of inspection visit: 9 September to 12  
September 2014

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

# Summary of findings

## Ratings

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

Requires Improvement



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

Requires Improvement



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

Requires Improvement



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

Good



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

Requires Improvement



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

Requires Improvement



# Summary of findings

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# Summary of findings

## Overall summary

Overall, this core service was rated as 'requires improvement'. We found that community health services for children, young people and families was caring, but required improvement to be safe, responsive and effective. We rated leadership as 'inadequate'.

East Sussex Healthcare NHS Trust delivers community-based services to children and young people, and their parents across East Sussex. It provides a range of services, including safeguarding children, services for 'looked after' children, health visiting, school nursing and community paediatric nursing.

Our key findings were as follows:

- There was varied use by staff of the Trust's reporting mechanism. We found that risks identified on the risk register and concerns raised by staff were still ongoing, with no assurance that they were being adequately managed.
- The risks and concerns about the delay of the introduction of electronic records, the problems with the IT system, the lack of administrative support and the risks with the Child Health Information Systems (CHIS) threatened the delivery of the services and the reliability of national health data.
- The community paediatrician vacancies on the risk register meant that there were waiting times of between eight to 15 months for appointments and there was not enough capacity for the designated doctor in safeguarding to cover the county; this was on the Trust's risk register but was a longstanding problem that should have been addressed more effectively.
- The school nursing vacancy rate on the risk register resulted in prioritising safeguarding work.
- There were no consistent systems to ensure an equitable distribution of caseloads in school nursing and health visiting and there was no overview of what the service delivered.
- The Trust was on its planned trajectory of recruitment to their workforce in response to the national call to action in the Health Visitor Implementation Plan 2011–2015.
- The parents we spoke with told us that the services were accessible and that staff were knowledgeable,

informative and caring, but there was no system of collecting feedback from people who used this service and so no method of using patient experience to drive service improvements.

- Staff demonstrated a passion for their work and spoke of the support within their teams. Staff spoke of good safeguarding supervision and support.
- There did not appear to be escalation processes in use or robust contingency planning.
- There was no clear audit programme.

We saw some good and outstanding practice, including:

- The WellChild Nurse service and the sexual health clinics which were 'youth friendly'.

However, there were also areas where the Trust needs to make improvements.

Importantly the Trust must:

- Review the current workforce establishment to ensure that there are sufficient numbers of skilled and experienced staff to meet the needs of the service.
- Have mechanisms in place to obtain feedback from service users and use this information to inform service planning.
- Have a robust Child Health Information System (CHIS) that produces reliable data.
- Review establishment of administrative staff and ensure there are sufficient numbers to support the service, especially during period of unstable CHIS and delays in implementation of electronic records.
- Have a system of monitoring activity key performance indicators (KPIs) and monitor service delivery to meet service specification.
- Implement an audit programme to monitor quality and safety of service.

The Trust should:

- Develop a robust communication process informing health visitors of miscarriages and stillbirths.
- Ensure staff use the Datix patient safety incidents healthcare software to report concerns and provide accurate Trust data.
- Provide clinical supervision for health visitors and school nurses.

# Summary of findings

- Improve communication processes from team-leader level to staff in the community and regular meetings about developments.
- Take an overview of what service staff are providing and why, linked to KPIs.
- Review the continence service, as there is a high demand, and the Trust is not able to meet the present needs.

# Summary of findings

## Background to the service

### Background to East Sussex Healthcare NHS Trust

Community health services for children, young people and families within East Sussex Healthcare NHS Trust includes safeguarding children, children in care, health visitors, school nurses and community children's nurses. Children form about 117,000 of the total 525,000 population. The trust employs 100 whole time equivalent (WTE) health visitors, 12 WTE community paediatric nurses, nearly 38 WTE school nurses and three safeguarding children's nurses (one of full-time and two part-time).

Many of the health visitors are based in the children's centres and run clinics in a variety of venues including in some of the 31 children's centres. We saw examples of integrated working in the form of interagency meetings to support families at two of the children's centres and a children's centre worker supporting parents who attended a child health clinic. The Trust does not run or manage the children's centres or employ the staff who work in them. Children's centres are a statutory service funded by the government through Sure Start for all families to access.

School nurses are based in health centres, clinics, community hospitals and a children's centre. The children's community nursing team has bases at both acute hospitals (Eastbourne and Conquest) and work closely with hospital staff and specialists. This means that service providers work together to offer integrated services to children and their families.

During this inspection, we attended some health visiting and school nursing bases, clinics, outpatient departments and services, both in the community and in hospitals. We observed care and support provided in these facilities and in clients' homes.

During this inspection, we spoke with around 32 parents and carers, five external health and social care professionals and 82 members of staff, including doctors, health visitors, school nurses, children's community nurses, specialist nurses, nursing staff, nursery nurses, administrative staff, managers and directors of service.

The team saw approximately 28 children including babies whilst receiving 'care' and we spoke to 32 parents/carers for their views of the service they received. During this we spoke generally with all members of the family present and generally with the school children we saw.

In health visiting where the children were four years and under they were seen with their parents either in clinics or at home. With two older preschool children we directly asked for their views did they like coming to the clinic (they were there with a younger sibling), one said yes – they liked the toys, the other was shy and moved away. It was not appropriate to ask children of two years and younger.

Children receiving the school nursing service were observed in school settings with the school nurse present and two children volunteered their views to the team on the school nurses. In the paediatric clinic two children of school age gave their views in some depth freely with a member of the team, with their parent present..

We spoke to staff who provided palliative care and complex care; the team observed a clinic and a home visit related to these services.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Mike Anderson, Chelsea and Westminster NHS Foundation Trust.

**Head of Hospital Inspection:** Tim Cooper, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: The team of 52 that visited across the Trust on 10, 11, 12 September and the team of five who visited the two district general hospitals on 23 September 2014 included senior CQC managers, inspectors, data analysts, inspection planners registered and student general

# Summary of findings

nurses and a learning disability nurse, a consultant midwife, theatre specialist, consultants and junior doctors, a pharmacist, a dietician, therapists, community and district nursing specialists, experts by experience and senior NHS managers.

## Why we carried out this inspection

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

East Sussex Healthcare Trust was rated as a band one risk in the July 2014 CQC intelligent monitoring data, (where band one is the highest risk and band six is the lowest risk).

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other

organisations to share what they knew. We carried out an announced visit between 10-12 September 2014. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with people who use the services. We observed how people were being cared for and talked with carers and/or family members and reviewed the care or treatment records of people who use the services. We met with people who use the services and their carers, who shared their views and experiences of the core service with us.

## What people who use the provider say

Parents and carers that we spoke with were positive about the care they received from the community children's services. They talked about kind and supportive staff. The feedback from people was very positive with people telling us staff were approachable and reliable.

We were not able to speak with any children who used the service as the inspection took place during school hours and the children we did meet had complex needs and were not able to talk to us.

## Good practice

Our inspection team highlighted the following areas of good practice:

- The WellChild Nurse service and the sexual health clinics, which were 'youth friendly'.

## Areas for improvement

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

# Summary of findings

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

- Review the current workforce establishment to ensure that there are sufficient numbers of skilled and experienced staff to meet the needs of the service. Where deficits are identified, appropriate action should be taken to resolve the issue without delay.
- Have mechanisms in place to obtain feedback from service users.
- The Child Health Information Systems (CHIS) must be robust and produce reliable data.
- Review the establishment of administrative staff and ensure there are sufficient numbers to support the service, especially during periods of unstable CHIS and delays in the implementation of electronic records.
- Have a system of monitoring activity key performance indicators (KPIs) and monitor service delivery to meet service specification.
- Have an audit programme to monitor quality and safety of service.

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

- Have a robust communication process informing health visitors of miscarriages and stillbirths.
- Ensure staff use Datix and report concerns in order to provide accurate trust data.
- Provide clinical supervision for health visitors and school nurses.
- Improve communication processes from team leaders and above levels to staff in the community, as well as having regular meetings regarding new developments.
- Trust to have an overview of what service staff are providing and why. At present, teams are operating in differing ways with no rationale/processes to explain why (this links in with developing KPIs).
- Review the continence service, as there is a high demand, and the trust is not able to meet the present needs.

East Sussex Healthcare NHS 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

**Requires Improvement** 

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

By safe, we mean that people are protected from abuse

### Summary

Services provided to children, young people and families requires improvement to be safe.

There was variable use of the Trust's reporting mechanism by staff. Staff told us that, for a year, the Trust had received reports from staff of not being routinely informed of miscarriages and stillbirths. Staff told us of the workload pressures in school nursing, the community paediatric vacancies, a lack of capacity in the named doctor for safeguarding children and that there were IT problems; we saw that these had also been identified on the Trust Risk Register.

Complaints about waits for community paediatrician appointments were seen and there had been many

complaints about the supply of continence supplies for children. The staff we spoke with told us these problems were ongoing and we were not assured that effective action had been instigated to mitigate the risks.

There were no consistent systems to ensure an equitable distribution of caseloads in school nursing and health visiting. School nursing staff informed us that they prioritised safeguarding work and this was seen to be an action in the school nursing service the risk register.

Procedures were in place to safeguard children and young people. Staff found the safeguarding supervision provided useful. We saw evidence of learning from serious case reviews (SCRS) and changes in practice as a result of this.

There had been a delay in the implementation of electronic client records, and at some nursing bases there were insufficient computers and ongoing problems with connectivity. This impacted on staff being able to retrieve information effectively or produce work such as reports.

There was inconsistency in checks conducted across sites and inconsistency in the availability of equipment. This meant the trust could not ensure the safety, or availability of their equipment.

## **Detailed findings**

### **Incidents, reporting and learning**

- There was a trust-wide electronic incident reporting process, which all staff we spoke with were aware of. Some staff told us they felt confident in reporting incidents and had seen action taken to reduce the risk of these incidents reoccurring. Some staff told us that this process was not used enough in community settings. Most staff described directly reporting concerns to their manager. A few staff spoke of being told by managers not to use the trust-wide incident reporting process.
- Health visitors told us that one area of concern they had reported was that they were not being routinely informed of miscarriages and stillbirths by the midwifery service. Health visitors told us that the poor communication issues identified with the midwifery service had been occurring for one year. The health visitors in their individual teams told us they tried to contact the midwifery department directly but that this took up a lot of time for both services. Staff told us there was no long term trust-wide plan to prevent these incidents reoccurring. No trust-wide system was in place to ensure health visitors were informed of miscarriages and stillbirths.
- Many school nurses and some health visitors told us they had reported workload pressures. Health visitors told us that the planned trajectory of recruitment to their workforce would help with the national call to action in the Health Visitor Implementation Plan 2011-2015.
- The Trust's risk register highlighted a vacancy factor in school nursing with a prioritising of safeguarding work. School nurses spoke of very high numbers of children subject to child protection plans on their caseloads, but spoke of the excellent support they received from the trust's safeguarding children's teams' advisers.

- The CHIS was on the risk register as it was at risk of being unable to fulfil its reporting of key national data. Staff told us that there was a lack of administrative support; managers spoke of the Trust holding administrative recruitment. Managers told us that the delay in the introduction of a community IT system was logged as a risk.
- A lack of capacity in the named doctor for safeguarding children and community paediatric consultant vacancies were both identified on the Trust's risk register. There was not enough capacity for the designated doctor to cover the county and there were waiting lists of between eight to fifteen months to see a community paediatrician.
- There had been complaints about the supply of continence products for children that required them. The service was not coping with the demand but effective action had not been taken to address this.
- Health visitors told us of learning from SCRs, and of changes in practice being implemented in a timely manner. There was a 'Top 10 Tips - Learning from serious case reviews' A4 guidance sheet for health staff, as well as all staff who would receive any information about SCRs. Policies and procedures were amended to reflect the learning from SCRs.

### **Cleanliness, infection control and hygiene**

- At Bexhill Hospital, where children were seen in outpatients, cleaning checklists for the toys were not available. This meant that it could not be verified when the toys and books were last cleaned or checked.
- We attended two child health clinics, one in a health centre, and the other in a children's centre. In one room, the layout inhibited access to the hand sanitiser and bins. In both settings, there was disposable paper lining the baby weighing scales and changing mats. Scales and changing mats were wiped clean and the paper changed between each baby. The staff present told us that the parents usually placed their baby on the baby weighing scales. Staff in the child health clinic used hand sanitiser between weighing different babies.
- At the two community paediatric clinics, a school visit with a school nurse and during four home visits we observed that staff used hand sanitiser or hand washing before and after any patient contact, as promoted by the World Health Organization's (WHO) 'Five Moments for Hand Hygiene' guidelines.

- We asked health visitors at the focus groups we held about hand hygiene practice, some did not demonstrate an awareness of hand hygiene practice. Hand hygiene audits were not available for health visitors or school nurses. This meant that senior managers could not be assured that all staff maintained good standards of hand hygiene.

### **Maintenance of environment and equipment**

- Three community hospitals that provided care for children in their outpatients departments were inspected. Where there was a minor injuries unit in the hospital, staff had a greater awareness of children's issues and maintaining a child-friendly environment.
- Uckfield Community Hospital included child safety in their environmental audits and regularly checked their outpatients department for potential hazards for children. As a result of these audits, sharps boxes had been moved out of reach. These hospitals had paediatric resuscitation equipment readily to hand and there were staff available who were trained in paediatric resuscitation.
- At Bexhill Hospital, where children were seen in outpatients, we found that paediatric resuscitation equipment was not available. This meant that children attending there could not be treated appropriately in a medical emergency.
- The majority of the health visitor bases and one of school nurse bases we visited were in children's centres that were not run or managed by the Trust. Equipment used, such as scales, were checked annually and calibrated through the Trust's maintenance programmes and there were dated labels on equipment seen during our visit.
- The delay in the introduction of the community IT system meant staff were still exclusively using paper patient records. Staff told us there were insufficient computers to ensure staff could access emails, forms and policies in a timely manner. Further computers and network points were required and there were ongoing connectivity issues across the area. This meant that staff did not always have the necessary equipment to carry out their work in a timely manner.

### **Medicines management**

- We met a staff member from the immunisation team who delivers the school health immunisation programme. Protocols were in place with appropriate checks and monitoring such as daily temperature checks and vaccines logged in and out.

### **Safeguarding**

- Staff we spoke with demonstrated good knowledge and awareness of safeguarding processes. They were able to describe the processes in place and knew how to escalate concerns. Most staff told us that they had good communication with social workers.
- Staff told us, and we saw evidence, that almost half of all referrals made to social care about children for whom there were child protection concerns were re-referrals (i.e. had been previously referred for the same reason). An audit to examine the quality of child protection referrals by Trust staff had been proposed but not actioned at the time of the inspection.
- The Trust safeguarding policy was reviewed in September 2014. The Trust worked in partnership with the local safeguarding children board (LSCB). The safeguarding children's team worked across the Trust and provided daily support on the hospital site and in the community.
- The safeguarding children team checked emergency admissions each weekday morning and liaised, as appropriate, with health visitors and school nurses. The safeguarding children's team also attended multiagency meetings with social care and midwifery colleagues about antenatal women for whom there were safeguarding concerns about their unborn child and liaised with health visitors.
- Health visitors and school nurses emailed the safeguarding children team about those patients receiving the Universal Partnership Plus service, which denoted a high level of need and support. The safeguarding children team then informed the minor injuries units, walk-in centres and emergency departments within East Sussex of those children. This meant that these services were aware of those children with high levels of need about whom there may be safeguarding concerns.
- The sexual health clinics had a dedicated children's medical records system which flagged up looked after children and all children under the age of 16. The

dedicated children's record system automatically included the Fraser guidelines (these are legal guidelines issued following a high court case about assessing whether a child under the age of 16 has sufficient maturity and capacity to consent to treatment) and all the information was reviewed and checked at every appointment with any changes that raised concerns flagged to the safeguarding lead. Weekly meetings were held with the safeguarding children's link nurse to audit the care and treatment of every child under 13 and a sample of the children under 16 who attended the clinic. This meant there were robust systems in place to identify and respond to those for whom there were safeguarding concerns, or high levels of need.

- There was a named nurse for the acute service and a named nurse for the community, a deputy named nurse, a named midwife, three safeguarding advisers, one named doctor for safeguarding and a designated consultant community paediatrician for child protection. There was also a children in care nursing team. The identified lack of named doctor capacity on the risk register was also highlighted by staff we spoke with.
- Children's safeguarding training at level 3 had been completed by 96% of health visitors, school nurses and community children's nursing staff.
- Staff reported they were able to access safeguarding advice as they required it and had regular, planned safeguarding supervision at timed intervals, depending on their role. All staff we spoke with found the safeguarding supervision useful. The Trust Child Protection and Safeguarding Children Policy was reviewed in March 2014.
- There was evidence that some learning had taken place following a Serious Case Review. We were supplied with an action plan that showed that actions had been completed. For example, that School Nurse Guidelines had been amended in light of the review recommendations.
- Learning from the SCR was disseminated across both acute and community children's services through monthly safeguarding meetings for staff.
- The child safeguarding team produced a bi-monthly newsletter to that was made available to all staff working in children's services.

## **Records systems and management**

- Health visitors and school nurses told us that they used paper notes solely for their patients. Staff and managers told us that there was a delay in the implementation of an electronic record system. In the offices we visited, we saw that the paper records were stored securely and were accessible to health staff, as appropriate.
- We reviewed twelve sets of patients records. The records we saw were clearly set out, legible, dated and signed. We saw varied evidence of the use of appropriate care pathways and protocols. Staff we spoke with showed us how they accessed policies on the Trust's intranet.
- We saw evidence that policies were regularly reviewed; some were amended in line with new national guidance.
- Staff told us there were insufficient computers to ensure staff could write reports, referrals and access emails, forms and policies in a timely manner. We saw incidences of slow connectivity when information could not be retrieved electronically, this impacted on staff's ability to work on reports and retrieve information.

## **Lone and remote working**

- We saw that staff were adhering to the lone worker policy. We were shown, in the staff bases we visited, a diary or whiteboard that outlined what each member of staff had scheduled in, so that colleagues knew their whereabouts.
- Staff carried work mobile phones and personal alarms. Two health visitors piloting extended working hours set out the precautions they took in ensuring their safety.

## **Assessing and responding to patient risk**

- Antenatal visits by health visitors were being provided to all pregnant women. This ensured that the needs of each woman were assessed prior to birth and that they received information about the services they could access for postnatal support.
- All staff we spoke with were aware of their role in safeguarding children and felt confident in reporting concerns about a child or young person's wellbeing.
- The Trust was delivering certain elements of the Healthy Child Programme (HCP) universally. We were told by managers that the minimum requirements as set out in the HCP for health visiting teams would be achieved

universally in March 2015. This would be in line with the expected increase in workforce through the call to action in the Health Visitor Implementation Plan 2011-2015.

- All the school nurse records we reviewed evidenced that clinical and risk assessments had been undertaken with care plans and up-to-date progress reports.

### **Staffing levels and caseload**

- The Trust's risk register described a vacancy factor in school nursing with a control being the prioritising of safeguarding and working with children and young people in care and those requiring Universal Plus (a rapid response from the health visiting team when families need specific expert help), Universal Partnership Plus provision. However, since the inspection visit the Trust has told us that school nursing services had moved to another provider.
- School nurses we spoke with told us that they were not able to provide the proactive public health role they were trained to provide. School nurses spoke of very high child protection numbers and said that caseloads were not allocated according to need. A school nurse described one occasion when they reported concerns about the caseload to managers; a meeting was set up with an interim provision of extra hours to support the team.
- Health visitor caseloads were broadly in line with levels recommended following publication of The Protection of Children in England; a progress report 2009. The recommended caseload for full time health visitors is 1 health visitor to every 300 children under 3 years of age. The Trust provided us with information that said the average caseload was 250-300 children per FTE Health Visitor.
- Some staff spoke of the impact of losing the family support practitioners a few months ago and how they

had provided expertise in supporting families in the community. One service we were told that had felt the impact of this was the continence service. Staff had used this service to help with strategies in toilet training and constipation. The continence service was described as not having the capacity to treat children promptly and effectively.

- Some health visitors we spoke with told us they used a weighting system for caseloads, however, there did not appear to be a consistent system used on a trust-wide basis.

### **Managing anticipated risks**

- There were plans in place for bad weather and staff demonstrated knowledge of the processes. Staff told us that in the event of staff sickness they would, and did, cover their colleague's workload.
- The delay in the implementation of the IT system, the inability of the Child Health Information Systems (CHIS) to fulfil its reporting requirements, together with a lack of administrative support, could adversely impact on health visitors and the school nurses' ability to work effectively.
- The vacancy factor in the school nursing service was identified on the risk register and a shortfall in the recruitment and/or retention of health visitors was identified as a potential risk on the trust's Health Visitor Implementation Plan 2011-2015.
- The number of children subject to a child protection plan had increased by a fifth over the last year and the number of looked after children had increased. Health visitors and school nurses prioritised work with children subject to a child protection plan. Health visitors undertook and reviewed health assessments for children in care. These two factors impacted on the level of service that health visitors and school nurses could provide.

# 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

The Trust was not meeting the minimum requirements, as set out in the HCP for health visiting teams due to workforce limitations.

There was a Trust health visitor implementation plan in place although local managers and staff could not provide information on KPIs or outcomes for the services provided. There was no clear audit programme in place for community children's services, which meant the quality of service was not being monitored and trends were not identified.

The delay in the implementation of the IT system meant that data and information was not easy to retrieve. The insufficient IT hardware in place did not promote effective working. The lack of administrative support and the problems identified in the CHIS adversely affected information and data being inputted and retrieved.

Shortages of some equipment, such as enuresis (bedwetting) alarms meant that some parents were waiting for equipment to borrow; this resulted in delays in treatment programmes starting and caused prolonged distress to parents and children.

There was a discrepancy between what the Trust told us and what staff told us in relation to staff supervision and appraisal. The Trust reported staff annual appraisal rates of 77% whilst the majority of the health visitors and school nurse that we spoke with told us they had not had any supervision or appraisals.

The Trust had not yet achieved UNICEF Baby Friendly accreditation.

Parents, children and young people were assessed and supported according to national guidance. There were good examples of multidisciplinary working. We saw evidence of the use of appropriate care pathways.

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## Detailed findings

### Evidence-based care and treatment

- Relevant National Institute for Health and Care Excellence (NICE) and other guidance were discussed and disseminated to the health visitors and school nursing staff through the quarterly professional development groups (PDGs). Examples of this included representatives from local agencies describing new support and entitlements available for families, children and young people.
- The community children's nursing team quarterly meeting discussed relevant national guidance and local practice. We saw evidence of national guidance in care pathways that staff used. We saw, in health visiting and school nursing records that we looked at, evidence of the use of the Framework for the Assessment of Children in Need and their Families to determine individual and family needs.
- The emphasis in the Healthy Child Programme (HCP) is on the early identification of need. We saw that the Trust had introduced a universal antenatal visit by health visitors in February 2014, in line with an increase in the health visiting workforce. This ensured that the needs of each woman were assessed prior to birth. The other elements of the universal HCP delivered were: a new birth visit between 10-14 days postnatally, a six week postnatal review, a questionnaire sent to all parents, carers of one year olds and a two year review.
- Not all elements of the HCP universal core programme were being delivered. The health visiting service specification 1 April 2014 to 31 March 2015 set out what should be provided, with some thresholds set by the workforce available, with others to be confirmed. We were told by managers that the minimum requirements, as set out in the HCP for health visiting teams would be achieved universally in March 2015. This would be in line with the expected increase in workforce through the call to action in the Health Visitor Implementation Plan 2011-2015.

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

- The Family Nurse Partnership (FNP) programme has been delivered by the Trust for six years; this is a licensed national programme with set core elements. The FNP is offered to support first-time mothers (and father/partners) aged 19 and under.
- The health visitors told us that they were runners up this year, in conjunction with the University of Brighton, for the Community Practitioner Team of the Year award. This was awarded by a professional body working with health visitors and school nurses.
- We saw that school nurses were using national patient-based directives to guide practice. Within the community children's nursing team we met a specialist paediatric diabetic nurse and a specialist paediatric epilepsy nurse, who were both involved in the regional strategic network.

## Nutrition and hydration

- Health visitors told us that the breastfeeding training, as part of the trust's accreditation for the UNICEF UK Baby Friendly Initiative, was about to start. Parents were able to access breastfeeding support in varying ways and at times and venues convenient for them. The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF first established in 1992. Most Trusts in England have already achieved accreditation.
- Health visitor clinics were available across the Trust where babies were weighed and measured. Parents could access advice on feeding and nutrition. Parents we spoke with found the service accessible and valuable.
- Children attending school were weighed and had their height measured in reception at primary school and in Year 6. East Sussex Public Health reported good coverage of this service with 99% of reception children and 97% of year six children being measured in the county.
- Whilst the information was collated and used for epidemiological purposes, it was less clear how staff at the Trust used the information to improve the healthcare of children. Staff told us that the staffing levels were such that their focus was very much on those with the highest level of need and that the public health aspects of their work was not prioritised.

## Approach to monitoring quality and patient outcomes

- The managers and staff we spoke with were unable to tell us what key performance indicators (KPIs) were being met across the Trust's health visiting, school nursing and community children's nursing service. This meant we could not determine what service was being delivered as information provided by the Trust did not distinguish between community and acute healthcare settings.
- We saw a health visitor implementation plan with elements of the HCP and dates that specified when the plan was to be rolled out. Health visitors told us they had seen this, most of the staff we spoke with told us they were achieving what was set out in this plan.
- Staff told us about high levels of need in the community and the high rate of work they had to do with families with complex needs. Some geographical areas in East Sussex were in the top 10% of the most deprived areas in England which resulted in high levels of intervention and impacted on the ability of staff to do other work.

## Patient outcomes and performance

- We saw vulnerability information recorded in individual patient records. We saw evidence that progress was monitored in patient's, children's and young people's records.
- We saw evidence of an audit being conducted in relation to a proposed Child and Adolescent Mental Health Services (CAMHS) pathway. A pathway for assessing children for a possible autism spectrum disorder was being proposed and audited, against NICE guidelines. We saw evidence of a FNP records audit being completed, but there was no clear audit programme in place and staff we spoke with did not know of audits being undertaken.
- The managers told us, and we saw evidence, of there being a risk of not being able to report key annual and quarterly data to NHS England. This led to incomplete information on which strategic healthcare decisions were made and created a lack of transparency about how the service was performing.

## Competent staff

- In September 2014 80% of health visiting, school nursing and community children's nursing staff had completed their mandatory training. 77% of these staff had

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

received an appraisal by September 2014. However, health visitors and school nurses we spoke with told us that they did not have formal clinical supervision or regular management supervision.

- Some health visitors we spoke with had not found the Trust induction helpful and had found it too hospital focused. Health visitors spoke of the challenge of supporting many student health visitors who were on placements with the Trust. There was a system in place to support the newly qualified health visitors who made up approximately 35% of the workforce. The recently qualified health visitors we spoke with told us they were well supported by their colleagues.
- Some staff told us that they found it hard to access training as there would be no staff to cover their work.
- We found some skills mix with nursery nurses supporting health visiting and school nursing teams.
- At Bexhill Hospital, where children were seen in outpatients, there were no staff trained or qualified to look after or promote the safety of children in the department.

## Use of equipment and facilities

- The shared use of some children's centres ensured that families and children accessed a safe and suitable environment. The centres we visited demonstrated that the facilities were well designed and planned for the people using the services. Information was clearly accessible in the children's centres.
- The delay in the implementation of the IT system meant that data and information was not easy to retrieve. The insufficient IT hardware in place did not promote effective working.
- School nurses and nursery nurses told us that there were shortages of some equipment that they used, such

as enuresis alarms. This meant that some parents were waiting for equipment to borrow and that the child's treatment plan could not be implemented until the equipment became available.

## Multidisciplinary working and coordination of care pathways

- We saw examples of multidisciplinary working and coordination with services outside the organisation. Examples we observed included Team Around the Family (TAF) meetings with children centre staff and health visitors present.
- We observed school nurses working with education professionals and mental health professionals as well as health visitors liaising with community midwives.
- The health visitors we spoke with told us that each surgery and children's centre had a health visitor linked to that service who would go there and liaise with them on a regular basis.
- The WellChild Nurse who worked in the community children's nursing team told us that they were able to coordinate complex care packages with commissioners for children being cared for at home.
- Some health visitors and school nurses spoke of cumbersome processes and referral criteria in referring children to therapies delivered by other providers. Staff we spoke with told us that this could result in having to re-refer or families having to wait a long time to access services.
- We saw some evidence of integrated care pathways, for example the Healthy Child Programme (HCP), the Care of Next Infant (CONI) programme, and the perinatal mental health pathway being used.
- We found consistency in the identification of families with high levels of need using the Universal Partnership Plus guidance in the HCP.

# 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

Parents and young people told us that the staff were caring. Staff listened to parents, children, and young people and treated people with dignity, respect and compassion.

## Detailed findings

### Compassionate care

- Parents we spoke with told us that they had no concerns about confidentiality with the community staff. We observed many examples of kind and compassionate care provided to parents and children during the visit.
- We saw that community staff listened to the parents, that school age children were listened to, their views encouraged and they were included in the discussion and decision making.
- We saw examples of situations where members of staff worked hard to build relationships, understand concerns and anxieties and that they respected parents' individual preferences. We saw examples of good communication with parents and young people with use of appropriate language.
- Most parents described the staff as supportive and informative. We heard comments such as: "I'm a first-time mum. They've been very helpful, been there if I needed them." Many parents commented on the service being accessible and the staff being approachable.

### Dignity and respect

- Parents we spoke with felt they were treated with dignity and respect by community staff. We observed individual community staff treating parents, carers and children with respect. They were approachable and encouraged questions and listened to everyone.
- We saw examples of client information in all children's centres and clinical areas we visited. We observed good care and support provided by school nurses and community children's nurses. Children were included in discussions and decision making. Information was offered, as well as clarity provided, regarding the confidentiality of discussions between school nurses and

- Children's views were taken into consideration.

### Patient understanding and involvement

- We saw examples of client information in all the children's centres and clinical areas we visited. We observed good care and support provided by health visitors, school nurses and community children's nurses.
- Children were included in discussions and decision making. Information was offered, as well as clarity provided, regarding the confidentiality of discussions between school nurses and children. Children's views were taken into consideration.
- We observed that health visitors provided information on how to access services and support in various formats.

### Emotional support

- We observed that clients were supported emotionally. Mothers we spoke with described discussions about their emotional wellbeing and how this had been supported.
- We saw there was a perinatal pathway for mothers presenting with postnatal depression within four months after giving birth. This pathway identified contacts and the NICE guidance questions to be used to assess a mother's emotional wellbeing.

### Promotion of self care

- We saw much information available to families and young people on health and wellbeing, as well as on specific health needs and conditions. These included information on accessing sexual health clinics, exercise and nutrition. Parents described the help and support provided in this respect.
- We observed school nurses working with young people on their management of certain conditions. The specialist community children's nurses who worked with children and young people also helped children and young people to learn how to manage their long-term health conditions.

# 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

Caseload management and allocation was inconsistent which resulted in varying levels of provision. Although we saw that health visitors responded to the needs of families, there was not a consistent approach to how they managed their caseloads. School nurses were unable to undertake proactive public health work and could only prioritise safeguarding work.

There were no opportunities for people who used the service to give feedback. The trust had not learnt from the trends identified in complaints, there were long waits for community paediatrician appointments and difficulties in the continence service were ongoing.

Whilst the children's community nursing service was effective at reducing admission, the service was limited to daytime hours and this meant that outside these times parents were reliant on the 111 telephone triage service or had to visit the accident and emergency department at the Conquest hospital.

Services such as the homeless team and the Family Nurse Partnership programme had been designed to respond to specific needs in the county and were used by the trust. The piloting of an extended hour's health visiting service was in response to the needs of fathers/partners and to support breastfeeding mothers.

We noted two areas of outstanding practice. The WellChild Nurse service, which worked creatively with commissioners and other providers to meet children's needs within the community. The sexual health clinics had made the service 'youth friendly' and had reduced the numbers of young patients 'walking out' of a clinic before being seen.

## Detailed findings

### Service planning and delivery to meet the needs of different people

- The health visiting specification for 1 April to 31 March 2015 demonstrated engagement with the commissioners of services. In the specification, thresholds were set for when certain elements of the Healthy Child Programme (HCP) were to be delivered according to the workforce. The Trust was on track to achieve the planned trajectory in the training and

recruitment of health visitors by March 2015. This increase in workforce was in response to the national call to action in the Health Visitor Implementation Plan 2011–2015.

- We were told that universal antenatal contacts were being delivered, this meant that needs were identified early and support offered according to those needs through the Universal Partnership Plus level of support.
- The health visitors did not have a consistent approach to how they managed their caseloads. There were no guidelines in place and we saw different methods of working. Some health visitors told us they were overloaded and unable to take on new cases. Some teams used caseload weighting tools to distribute the cases to health visitors depending on need and the capacity of the health visitor.
- School nurses we spoke with told us that weighting tools were not used and that there were vast differences between the needs of different school nursing caseloads.
- Staff told us that there were parts of the county with a highly transient population. The Trust had a homeless health team with a health visitor, which provided healthcare and support to people who were homeless or at risk of being made homeless.
- Staff from the sexual health clinics told us of areas within the county that had a teenage unplanned pregnancy rate above the national average. They told us about the work they had done to make the service 'youth friendly' and reduce the numbers of young patients 'walking out' of a clinic before being seen. This included positive discrimination for any young person under the age of 16, dedicated care records for those under 16 and weekly meetings with the safeguarding link nurse to flag particular issues such as 'looked after' children.
- There was no dedicated midwife or health visitor with specific skills in meeting the needs of young mothers.
- The community children's team told us that the service they provided prevented some children being admitted into hospital, for example neonates requiring oxygen therapy and children being able to receive some types of chemotherapy at home.

# Are Community health services for children, young people and families responsive to people's needs?

- One of the nurses in the safeguarding children team told us how a multiagency regional meeting involving three different Trusts had been set up. This was to address the challenge of antenatal women with high needs accessing any one of the three hospitals in these trusts.
- The WellChild Nurse service told us that they were able to respond to the individual needs of children with complex needs so that children could be cared for at home.

## Access to the right care at the right time

- We were told by staff that there were long delays in getting a first appointment with a consultant paediatrician. Reported referrals to appointment times were said to be up to 18 months in some instances. This meant that treatment and care plans were also delayed and that the problem could be exacerbated by waiting.
  - The Trust has taken some action to reduce the impact of the lengthy delays in being offered a first appointment and told us that they felt the waiting list would be cleared within 6 – 12 months.
  - Patients on the waiting list were triaged and offered telephone contact and an initial pre-assessment with a nurse. They were signposted to alternative therapists, where appropriate. A band 6 nurse was working two days each week providing a triage service based at the Scott unit in Eastbourne.
  - Three consultants paediatricians were working on Saturdays to provide additional capacity.
  - Health visitors offered their services between the hours of 9am and 5pm. The health visiting team was piloting an extended hour's service with two health visitors offering extended hours from 8am to 8.30pm. The aim was to be able to support breastfeeding with the roll out of the UNICEF UK Baby Friendly Initiative and offer visits later when fathers or partners were at home.
  - Staff told us that they were able to refer children for whom there were child protection concerns within the timelines set out in the policy.
  - In school terms, the core hours for the school nursing service was 9am to 5pm, during the school holidays, there was a reduced school nursing team available.
  - We saw evidence of patient-centred care that showed community staff were responsive to individual needs and worked flexibly with them towards improving the patients' health and wellbeing. We saw that service providers had worked together to plan appropriate service provision.
- Staff were able to see parents and carers at times and places convenient to them. Child health clinics were held regularly in children's centres, health centres, community centres and surgeries and parents were able to access these as they wished. Parents could also ring health visitors for advice or leave a message for the health visitor.
  - We did not see a consistent approach in how health visitors managed their caseloads; processes were not consistently in place. Some health visiting teams had processes, such as a duty health visitor who responded to messages and weekly allocation meetings, to determine what care clients required and that elements of the Healthy Child Programme were met.
  - Some staff we spoke with told us there were difficulties in accessing the right care at the right time in the continence service, the community paediatric clinic, and in some services delivered by another provider.
  - We were told that health visitors undertook the review health assessments for children in care within the statutory time limit.
  - Many children with complex needs were given open access to the paediatric unit at the Conquest hospital. The community teams worked hard to prevent admissions but the restriction of the availability of the service meant that there was no out of hours provision and parents without open access had to use the 111 service or visit the accident and emergency department.
  - The community children's team had also put forward a business case for extending the service to seven days a week, from 8am to 10pm and were awaiting the outcome.

## Discharge, referral and transition arrangements

- Health visitors we spoke with told us they spoke to school nurses to provide a detailed handover meeting for children moving into their service.
- Staff told us that they had varied experiences of liaison with midwifery in the postnatal period, some were very positive and others less so.
- The health visiting service specification set out that health visitors must make contact with families who have a preschool child who transferred into their area within 10 working days. The specification also set out what was required when a child moved out of area. We could not see if this was being achieved.

# Are Community health services for children, young people and families responsive to people's needs?

## Complaints handling and learning from feedback

- The staff we spoke with knew the process to follow if someone wished to make a complaint. We saw evidence of the complaints received for community children and young people's services. The complaints focused on the provision of continence supplies and delays in community paediatric appointments.
- Managers told us the provision of continence supplies to children had been reviewed. There was a specialist continence nurse and nursery nurse for this service who regularly reviewed children and promoted strategies. We heard from staff that there was an increase in referrals to this service and of children requiring support and that the service was not able to meet the increased demand.
- We saw information about complaints were discussed at directorate level and saw this documented in the Trust board minutes.
- Although action had been taken to address the individual complaints logged, staff told us there were still ongoing problems in these areas. The lack of community paediatricians was ongoing, with staff telling us of delays in community paediatric appointments. This meant that Trust had not learnt from the trends identified and had not put in permanent measures to resolve them.
- We did not find regular opportunities for people who used the services to comment and feedback to the trust. Managers told us an adapted NHS Friends and Family Test was to be introduced into the community later this year.

# 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

Communication was not always clear from management, staff told us that there was a perceived gap in communication between the board and those working in the community. Staff reported feeling disengaged and undervalued by the Trust.

There was no assurance as to how the risks identified on the risk register and the concerns reported were to be managed. The delay in the implementation of the electronic records, the issues with the IT system, the lack of administrative supportive issues, and the risks with the Child Health Information Systems threatened the delivery of the services and of reliable national health data.

There did not appear to be robust contingency planning or an escalation process. Teams supported each other as far as they were able to, on an informal basis. There was a difficulty for some to deliver a high quality service with collaborative strategic work and undertake essential training.

The Trust was on track to train and recruit health visitors in response to the national call to action in the Health Visitor Implementation Plan 2011-2015. Staff were positive about their teams and their team leaders and how they worked and supported each other.

There was some innovative work and succession planning.

## Detailed findings

### Vision and strategy for this service

- During the trust's presentation to the Care Quality Commission, we were shown the trust's vision and values – 'Our Values, We Care' – promoting integrated working, improvement and development, engagement and involvement and respect and compassion. Most staff told us that they felt the focus of the trust was on the acute sector. A few of the staff we spoke with could tell us about the trust's vision and values.
- Some staff told us that staff received a weekly email from the chief executive. Some staff told us how they had talked to senior Trust staff on the 'quality walks' (where a senior team from the hospital visit a service

and look at the quality of service provided, usually from the patients perspective) they had conducted. We saw that concerns voiced to these senior staff during the quality walks were documented in trust board minutes.

- Many of the health visitors we spoke with were able to tell us about the future plans for the service, as set out in the trust's Health Visitor Implementation Plan 2011–2015 for this financial year.
- The community children's nurses had put forward a business case for extending their hours and felt involved in shaping their service.
- The school nurses had recently been informed that the school nursing service was being transferred to another provider early next year which had impacted on morale and raised the level of anxiety within the teams.

### Governance, risk management and quality measurement

- The health visitors and school nurses had practice development groups every quarter and the community children's nurses had an operational meeting every quarter. Minutes seen from the practice development group showed a focus on practice guidance for staff.
- We saw that these groups reported into team leader meetings that then reported into the clinical services operational meeting. The clinical services operational group included the head of nursing, the clinical service manager for health visitors, school nurses and community children's nurses, a team leader from each and the perinatal mental health lead. This then reported into the Quality Standards Committee and the Trust board.
- Some health visitors and school nurses told us that communication from managers was often not clear, with verbal instructions given, rather than written guidance. Many staff we spoke with felt there was a gap in communication between the trust board and those working with clients in the community.
- There were several risks identified that were relevant to this service on the risk registers. Namely, the risk of a lack of available capital funding and the possible impact on buildings and IT systems, the community paediatric

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

consultant vacancies, the data reporting risks of the Child Health Information Systems, the vacancy in the school nursing team and the lack of capacity in the named safeguarding doctor.

- Managers told us they had concerns about the long-term availability of suitable accommodation for health visitors.
- There was no clear audit programme.
- We saw that learning from serious case reviews was disseminated.

## Leadership of this service

- Most staff spoke of their team leaders providing great support, but there were mixed views about more senior staff.
- The staff who told us about the concerns they had around specific communication issues, the lack of administrative support and workload pressures told us these had not been resolved.
- Several staff told us that they had been told that budgetary constraints were behind action not being taken to resolve reported issues.
- We found some staff, especially within school nursing teams with caseloads high in child protection, were 'firefighting'. Staff told us they were supported well by the safeguarding children team and within their team.
- Staff we spoke with were unsure about an escalation process. Many staff told us that they offered and did give help to colleagues in other caseloads if those teams were struggling to manage their work and they were able to help.

## Culture within this service

- All community staff we spoke with described their own teams as supportive and felt they communicated and worked well together.
- All community staff we spoke with expressed pride in their services and were proud to be working as part of the NHS. All staff told us that they enjoyed their work, but some felt constrained by large caseloads with high need and the need to prioritise this work.
- Many staff told us that they did not take adequate breaks, due to workload pressures. The staff survey showed that about half of all staff working with children and young people in the Trust had felt unwell in the last twelve months due to work-related stress.

- Some specialist nurses told us it was difficult to balance delivering a high quality service with collaborative strategic work and undertake essential training, as there were no replacement staff to cover the service.
- A few staff told us that individual concerns they had voiced about working conditions had been not been responded to.

## Public and staff engagement

- Staff spoke positively about the Listening into Action™ scheme, where staff identified ways to improve the service. An example of this was the piloting of two health visitors offering extended visiting and working hours from 8am to 8.30pm.
- Staff told us that they did not feel the flow of information from them to the top of the Trust was effective.
- We did not find any systems in place to ensure regular feedback for analysis, action and learning on the service provision.
- An adapted NHS Friends and Family Test was being introduced into the community later this year.
- Some staff told us how they had talked to senior trust staff on the 'quality walks' they had conducted in the community.

## Innovation, improvement and sustainability

- The call to action in the Health Visitor Implementation Plan 2011–2015, together with the proposed health visitor training and recruitment figures for 2015 were on track. 35% of the health visitors were newly qualified.
- Staff told us there was good succession planning, with many 'home grown' staff that were progressing in their careers.
- Specialist nurses were in post to provide specialist care to children with complex needs and long-term conditions.
- The community nursing team had put a business case forward for a seven-day service from 8am to 10pm.
- The school nursing service was to be taken over by another provider in January 2015.

# 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.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing

The provider had not ensured that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed in order to safeguard the health, safety and welfare of service users

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

There were not always enough suitably skilled and experienced staff in school nursing, community paediatrician and named doctor safeguarding.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA 2008 (Regulated Activities)  
Regulations 2010 Respecting and involving people who use services

The provider did not have suitable arrangements in place to enable service users to express their views of feedback to the service.

This is a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Outside of the community hospital setting there was little evidence of staff awareness or engagement with the value of patient feedback systems. We found that patients receiving care in their own homes were not generally encouraged or supported to provide formal feedback on the services they received.

### Regulated activity

### Regulation

# Compliance actions

Treatment of disease, disorder or injury

Regulation 20 HSCA 2008 (Regulated Activities)  
Regulations 2010 Records

The provider did not have suitable arrangements in place to maintain accurate records and proper information.

This is a breach of Regulation 20 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Child Health Information Systems (CHIS) must be robust and produce reliable data.

## Regulated activity

Treatment of disease, disorder or injury

## Regulation

Regulation 23 HSCA 2008 (Regulated Activities)  
Regulations 2010 Supporting staff

The provider did not have suitable arrangements in place to provide sufficient and detailed information to evaluate and improve the quality of services provided.

This is a breach of Regulation 23 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Specifically, the provider did not have a meaningful system of monitoring activity key performance indicators (KPIs) and monitor service delivery to meet service specification. Additionally, the provider did not have a sufficiently robust audit programme to monitor quality and safety of service.