

## North Bristol NHS Trust

RVJ

# Community health services for children, young people and families

### Quality Report

During this inspection we visited the following  
registered locations:

Eastgate House

Eastgate Centre

Bristol BS5 6XX

RVJT9

Tel: 01179505050

Website: [nbt.nhs.uk](http://nbt.nhs.uk)

Date of inspection visit: 4-7 November 2014

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

# Summary of findings

## Ratings

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

Outstanding



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

Good



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

Outstanding



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

Outstanding



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

Good



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

Outstanding



# Summary of findings

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# Summary of findings

## Overall summary

The Community Children's Health Partnership (CCHP) had systems in place for incident recording, investigating and monitoring. Lessons were learnt when necessary to prevent similar incidents from happening again.

Safeguarding procedures were in place with clear lines of reporting. Staff were aware of these procedures and their own responsibilities for the safeguarding of children and young people.

Staffing was stretched at times because of a growing child population in Bristol and South Gloucestershire. Plans were in place to review staffing and caseloads to manage this increase.

Involving children and young people was routinely undertaken across the CCHP and was seen as an example of outstanding service nationally. The feedback we had from children, young people and their parents or carers was extremely positive in all the locations and programmes we visited.

Staff were well trained and competent. Staff were kind and caring and we observed excellent interactions between them and children and young people and their parents or carers.

The CCHP worked in partnership with other agencies such as the local authority, education and Barnardos. We saw evidence that partnership working was routinely included in every aspect of their work. The sole purpose of the CCHP was to improve services for children and young people.

The CCHP provided some unique services to children and young people. These included the Be Safe project and a project managed by Barnardo's Child Sexual Exploitation (BASE) to which the CCHP second a CAMHS nurse. These were recognised nationally as areas of outstanding practice.

The service was well led and staff had a clear vision of the future of the CCHP.

Governance arrangements were in place, with clear lines of reporting from clinical hubs through to the trust board.

# Summary of findings

## Background to the service

North Bristol NHS Trust's Community Children's Health Partnership (CCHP) was formed in 2009 after a consultation process to have one provider delivering community children's health services in South Gloucestershire and Bristol. Barnardo's was chosen as a partner with North Bristol NHS Trust and forms a distinctive element in this CCHP partnership with user participation. Both Bristol and South Gloucestershire local authorities commission CCHP to provide a range of community services for children across their authority areas. Currently this service is provided to over 80,000 children and young people.

During our inspection we talked with 34 staff, 10 parents and 10 children and young people. We also visited the CCHP clinical hubs at Eastgate, Westgate, Kingswood and Patchway. We went out on visits with the school nurses and health visitors. We observed clinics with the community paediatricians and therapy staff, and various programmes operating within CCHP.

## Our inspection team

Our inspection team was led by:

**Chair: Andy Welch, Medical Director,** Newcastle upon Tyne Hospitals NHS Foundation Trust

**Head of Hospital Inspections: Mary Cridge,** Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: Consultant paediatrician, nurse and student nurse.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they

knew about the hospital. These included the two local commissioning groups, the NHS Trust Development Authority, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We held a listening event in Bristol on 3 September 2014, when people shared their views and experiences. More than 35 people attended the event. People who were unable to attend the event shared their experiences by email or telephone.

We carried out announced inspections on 4, 5, 6 and 7 November 2014. We held focus groups and drop-in sessions with a range of staff, including nurses, junior

# Summary of findings

doctors, consultants, student nurses, administrative and clerical staff, physiotherapists and occupational therapists. We also spoke with staff individually as requested.

We talked with patients and staff from across most of the trust. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of their care and treatment.

## What people who use the provider say

We had very little information prior to the inspection about what children and young people or their families thought about the service. During the inspection we spoke directly with children, young

people and their families who use the services. All people we spoke with during the inspection were extremely

positive about their experiences of using services and stated they had received support that was appropriate for their needs from caring, committed, skilled and knowledgeable staff.

## Good practice

Our inspection team highlighted the following areas of good practice:

- In safeguarding assessments the views of the child was clearly assessed and recorded.
- Excellent multidisciplinary and multiagency working through programmes such as the Be Safe Programme for children and young people who had shown inappropriate sexual behaviour.
- User participation was routinely undertaken. Benefits had been demonstrated such as effective communication, relationship building, active listening and had improve their and their parents or carers wellbeing.
- The Barnardo's Child Sexual Exploitation (BASE) project focused on young people who were at risk of exploitation. The project focused on increasing awareness of child exploitation. Staff worked with young people who had been exploited and looked for vulnerabilities that could lead young people to be exploited. This service was seen as innovative because of the way the service had been integrated into CCHP.
- The ethos of family-centred care was visible across all the teams within the Community Children's Health Partnership (CCHP). Children and young people were full partners in their own care, and the collaboration with Barnardo's meant innovative ways were explored to increase participation and improve care.
- The needs of children and young people were central in the planning of any service within CCHP and this was done in conjunction with other agencies and working in partnership with them for the benefit of children and young people.
- Working in partnership with other agencies and professionals routinely happened within CCHP Joint managerial meetings took place regularly with CCHP staff and Barnardo's staff, and the relationship was respectful and close, with constructive challenge.
- The Helping Young People Engage (HYPE) project was run by Barnardo's. Project workers were aligned to the two local authority areas in Bristol and South Gloucestershire as part of the CCHP. This partnership was unique and was being observed by senior researchers, government and health organisations across the country. The partnership was about bringing together the skills and experience of Barnardo's and North Bristol NHS Trust to address inequalities in health provision to improve outcomes for all children and young people and their families, especially the most vulnerable, and to have children's experience at the centre of decision making.
- A unique example of participation was the inclusion of young people on interview panels. Young people were given mentoring and preparation training. Monitoring that had been done following interviews showed that 100% of both professionals and young people felt the young people had significant influence in the final decision for recruitment of new staff.

# Summary of findings

## Areas for improvement

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

The trust should ensure that staff receive feedback following the submission of an incident form

North Bristol 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

**Good** 

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

By safe, we mean that people are protected from abuse

### Summary

Services provided by the Community Children's Health Partnership (CCHP) were safe. There was an open culture in reporting incidents and there were systems in place to learn from incidents and reduce the chances of them happening again. Robust safeguarding systems were in place for children and young people. The partnership had a strong risk-management process and we saw evidence that risk assessments had been completed.

### Incidents, reporting and learning

- Incidents were reported using a trust-wide electronic system. Staff were aware of this system and the trust policy on reporting incidents. Staff knew their responsibilities in reporting and acted in accordance with the policy.
- Monthly reports on incidents were provided to managers and professional leads. Quarterly reports were also produced on trends and themes for each area. Incident reports were produced for the commissioners.
- The minutes of individual team governance meetings showed that trends and themes were discussed and learning identified. For the period April 2013 to March 2014, there were 312 incidents reported. Staff were aware of the incidents that had taken place and what the themes were for their clinical area.
- Staff did not always receive feedback on incident investigation, but told us this had improved this year. Senior managers within the CCHP were aware that more needed to be done to feedback investigations to staff



and action had been taken to resolve this. One action included senior managers from the CCHP attending individual team's governance meetings to feedback on incidents.

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

- All the places we visited were clean and well maintained.
- An infection control policy was in place. Staff were aware of the policy and their own responsibilities around hand hygiene and reducing the spread of infections.
- We observed staff during home visits and clinic appointments washing their hands and using hand sanitizer appropriately. Personal protection equipment was used as necessary.
- Signs were displayed in public areas such as clinic waiting rooms emphasising the importance of good hand hygiene. Other notices were also on display for specific infectious diseases such as Ebola.

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

- Equipment was maintained according to manufacturers' instructions. Electrical equipment had been checked to make sure it was safe to use.

### **Medicines management**

- A medicines management policy was in place across the whole trust. Parts of this policy applied to the community service.
- No medicines were stored at any premises. When medicines were required for the school immunisation programmes they were supplied centrally via the trust's pharmacy.
- The Learning Disability team used an independent/ supplementary prescribing system. This system was an agreement between the prescriber (usually the doctor) and the supplementary prescriber (a nurse or pharmacist). This followed an agreed patient-specific clinical management plan, which detailed how much or how little responsibility for the medicines was delegated. A clinical management plan detailed the medicines it related to, any adverse drug reactions and review arrangements. This provided the child and young person with quicker, more efficient access to medicines, reduced the workload for doctors, ensured patient safety and made the best use of the specialist skills.

### **Safeguarding**

- A quality assurance audit was completed in June 2014 to review how effectively North Bristol NHS Trust shared information about children attending the A&E department with members of the primary health care team, including health visitors and school nurses. Following recommendations in Lord Laming's report on the Victoria Climbié Inquiry (2003), liaison between hospitals and community health services plays an important part in protecting children from deliberate harm. We saw that the trust's safeguarding children policy supported this recommendation under consent and information sharing. The trust also had guidelines in place for the local delivery of the Healthy Child Programme, which stated faxed notifications must be forwarded by the health visitor or school nurse to the child's GP within 48 working hours, in line with the safeguarding policy. The audit highlighted the good practice of sharing information between health visitors, school nurses and GPs. There was a robust system in place and all children attendances in North Bristol NHS Trust were faxed to the correct number for each health visitor or school nurse.
- When children were seen in the A&E department at Southmead Hospital, the health visitors or school nurses were informed. Health visitors and school nurses were then responsible for forwarding this information to the child's GP and to other professionals such as social workers when necessary. We saw evidence that this took place.
- Audits on keeping the emphasis on the voice of children and young people in health visiting services were undertaken in 2014. The aim of the audit was to assess if health visitors were documenting the voice of the child and what the child's daily living experience was of living in the family. The expectation for health visitors' documentation would be 100% compliance with the standards set. The results ranged from 73% to 84%. An action plan was developed; which included circulating the results to health visitors, developing additional training to make sure newly qualified health visitors in particular could interpret the voice of the child. A checklist was produced to ensure 100% compliance at the planned re-audit.
- In February 2014, a multi-agency audit on child sexual abuse referrals was undertaken. The aim of the audit was to find out if the concerns of child sexual abuse

were appropriately addressed at the strategy discussion stage and to identify how cases were escalated along the child protection pathway. The audit found strategy discussions were held on all referrals and the majority of actions identified as part of the strategy discussion were appropriate. When actions were identified that were not appropriate, these were discussed with the safeguarding teams and the local authority safeguarding children's board.

- Audits for the safeguarding assessments for school nurses showed good practice with comprehensive assessments where the voice of the child was clearly assessed and recorded.
- Child protection supervision was found to be comprehensive across all professional groups. This supervision ranged from one-to-one supervision regularly throughout the year to group supervision every four months. For the medical staff, supervision also included locality peer review and reflective practice.
- A named nurse and doctor were available for Bristol and for South Gloucestershire.
- We spoke with the safeguarding leads. They confirmed that all staff were required to have had safeguarding training at level three. Training records showed that 93% of staff had completed the training. Plans were in place for staff to receive the appropriate training, if needed.
- There was a community paediatrician on call 24 hours a day for any safeguarding issues such as medicals, so that they happened in a timely way. They explained that the safeguarding team worked closely with Bristol Children's Hospital and had access to their dedicated suite of rooms for safeguarding medicals. Excellent links were established with the A&E department at Southmead Hospital and the safeguarding team delivered training to the department staff on safeguarding children.
- Child death rapid response reviews took place for all children and young people under 18 years who had unexplained deaths. A consultant paediatrician would liaise with social services and the police, be involved with a joint assessment with the family and provide reports to the coroners and pathologist. They would also coordinate the child death review meeting and feedback, and arrange support for the family. Where learning was identified, it was cascaded to staff through operational and governance meetings. When

appropriate, learning that had been identified was address through training, such as how staff can communicate with parents involved in safeguarding to avoid them feeling blamed.

- The CCHP had clear lines of reporting through the safeguarding leads through to the safeguarding group for children and ultimately to the trust-wide safeguarding committee chaired by the director of nursing.

### **Records systems and management**

- Records were up to date and reflected the needs of each individual child and young person. We saw examples where clinical staff had updated individual records after each consultation.
- Entries were signed and dated and followed good practice guidelines on record keeping from professional bodies such as the General Medical Council and the Nursing and Midwifery Council.

### **Lone and remote working**

- A lone worker policy was in place across the trust. We found this policy to be comprehensive when considering the safety of its staff when working alone.
- The CCHP had a checklist in place for all its services in relation to lone working. This included whether individual teams had received up-to-date training, and if they were aware of local procedures, were issued with appropriate safety equipment, were aware of the need to keep in contact with colleagues and the procedures about reporting any incidents. We saw confirmation that all the services within the CCHP had confirmed their adherence to trust policy.
- The CCHP had effective systems in place to reduce the risk to staff who worked alone. These included check-in arrangements and, when concerns had been identified, joint visits.
- Health and safety audits were completed in relation to lone working. Each area had action plans when necessary, relevant to their own individual area. Staff also received visits from the health and safety link worker for additional advice.
- The staff we spoke with during this inspection were aware of the lone working policy and the measures they needed to take to maintain their own safety during home visits.

### **Mandatory training**

- Staff were well trained. Mandatory training such as safeguarding had been completed yearly. The overall trust target was for 85% of staff to have completed their mandatory training. Training records showed that in the majority of areas the CCHP was within the trust's target. For example, 88% of staff had completed health and safety training and 87% had completed infection control training. If the CCHP had not met the trust's targets, plans were in place to make sure staff had the training.

### Assessing and responding to patient risk

- We saw that within the Be Safe programme, each child and young person had an agreed safety plan. This plan was reviewed constantly with staff, parents or carers, and the young person themselves. The plans were discussed at the regular staff meetings to ensure a multidisciplinary approach.
- Staff were aware of the risks, such as possible safeguarding issues or cultural issues associated with missed appointments, and would call families the day before their appointments, as a reminder. Text messages were also used.

### Staffing levels and caseload

- The CCHP had a number of different clinical teams, such as health visitors, school nurses, Be Safe programme staff and the learning disability team.
- The Be Safe programme was staffed with a range of professionals, including psychologists, family therapists and staff with social work backgrounds. The staffing levels were adequate for the numbers of children and young people being seen. The staffing allowed two members of staff to facilitate each of the group meetings.
- The looked-after children team saw 17 new referrals from April to June 2014. This increased to 24 new referrals from July to September 2014. Staff told us they had capacity to see eight new children a month in two separate clinics, therefore the referral rate was within their capacity. Each looked-after child was required to have an assessment at 28 days. This had taken place and there had been no breaches.
- The CCHP had five clinical hubs, which served as bases for their clinical teams such as health visitors and school nurses. Attached to each team were consultant community paediatricians. The population in Bristol and South Gloucestershire is growing and therefore demand is increasing. Monthly referrals to the CCHP

have increased from 365 in November 2013 to 496 in October 2014. This increase in capacity was being met with their current establishment of staff. Senior CCHP managers were constantly reviewing the staffing levels and planning for future increases in the numbers of children and young people in Bristol and South Gloucestershire.

- The attention deficit hyperactivity disorder (ADHD) nurse specialist was responsible for 100 children. We were told that this was a manageable caseload and allowed the children to be seen every three months by the Child and Adolescent Mental Health team and six-monthly by the paediatric team. In addition, parent support groups were organised every three weeks in line with the NICE guidelines.
- The school nursing team has seen a 19% increase in the child population in the last five years. Currently the team provide a service to 46,446 school-age children.
- The health visiting service had 156.08 whole time equivalent staff in post (October 14) against an establishment of 182.10 whole time equivalents. The services has a trajectory to achieve full establishment in 2015.
- The health visiting service was responsible for 41,493 children up to the age of five. Information supplied by the trust showed us that the service was short of staff and that this was on the trust's risk register. Senior managers for the CCHP advised us there was a rolling advert for health visitors. They had recently retained all the newly qualified health visitors to fill the staffing shortfall. However, they also acknowledged that these newly qualified staff had to receive training and mentorship and develop their experience. The skills mix was under review, with qualified nurses (not health visitors) to support the health visitors and where necessary bank staff were used.
- Lord Laming's report (2003) indicated that a health visitor should have no more than 400 cases at any one time. The Community Practitioners and Health Visiting Association suggest this should be reduced to 250. The case loads for each health visitor were audited monthly using case load weighting (a scoring system based on the needs of each child and family). The health visitor caseload for the CCHP was now within these lower suggested limits.
- Sickness within the CCHP was 4.06% compared with the overall trust sickness rate of 4.24%.

### **Managing anticipated risks**

- The CCHP monitored health and safety. An action plan was in place to ensure departments complied with health and safety policy, including assessing risks and monitoring compliance.
- We looked at the risk assessments for one clinical hub and found these were up to date, with yearly reviews. The risks included violence and aggression, toys, clinical areas, waiting areas and personal protective equipment. When necessary, safe systems of work were introduced to minimise risks.



# 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

We saw some outstanding examples that showed the Community Children's Health Partnership (CCHP) was effective. Policies and guidelines were all evidence based and we saw excellent examples of multidisciplinary and multi-agency working and collaboration. Consent was always sought from children and young people as well as their parents. Staff at all levels demonstrated their commitment to work in partnership with others to achieve the best possible care for children and young people.

## Evidence-based care and treatment

- Policies and guidelines were based on the latest evidence and best practice.
- There was a programme of care in place aimed at children and young people who had shown inappropriate sexual behaviour, the Be Safe programme. The programme was run with the University of Oklahoma in the USA. It was evidence based and part of a research study to assess its effectiveness. This was a unique service for children and young people in the UK. Research from a similar programme in New Zealand found evidence that the programme was cost-effective compared with other treatments and the cost of offending. The research found that the service had a significant impact on lowering possible offending in young people.
- There is a attention deficit hyperactivity disorder (ADHD) service pathway in CCHP. The audits of this pathway had shown benefits to both children and young people. These included quicker access to care, increased choice, greater involvement, increased supervision, care and safety of children and young people with ADHD. For the organisation, the benefits were optimising skill mix and resource use, meeting access targets, increased multidisciplinary team working, reduction of wasted medicines and good clinical governance.

## Approach to monitoring quality and people's outcomes

- The Be Safe programme was currently undergoing research studies to provide evidence of its effectiveness. However, anecdotal evidence from staff included that

children had had significant improvements in their behaviour and from parents that the programme had made a difference to their child. Improvements in the behaviour meant they were less at risk of committing any offence and they were better equipped to stay safe and to respect the safety of others.

- Across the CCHP, user participation was routinely undertaken. A research project that looked at the benefits of this participation was ongoing at the time of our inspection. It had already identified positive benefits to children and young people from their involvement in participation work. It had provided opportunities for young people and parents to develop life skills in effective communication, relationship building and active listening. They gained new knowledge about themselves, other people who ordinarily they would avoid and how society functions. These new skills and knowledge had enabled children, young people and their parents or carers to improve their wellbeing.
- CCHP undertakes all of the core requirements for the Department of Health's 'Healthy child programme'. This includes early intervention, developmental reviews, screening, prevention of obesity and promotion of breast feeding.

## Competent staff

- Additional training needs were identified through supervision and through performance reviews. Staff were encouraged to seek additional training as necessary to develop their roles and were supported in doing this by the CCHP management team.
- When necessary, such as within the Be Safe programme, staff had been trained in intervention. The ADHD nurse had received additional training in counselling and mental health.
- Health visitor and school nurses had to complete school health nursing competencies for immunisations before they were able to administer immunisations. We saw evidence that these assessments were in place and had been completed by staff.



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

- Comprehensive supervision arrangements were in place for all clinical staff. This ranged from group through to one to one supervision. The staff we spoke to during our inspection felt the level of supervision for their individual roles was good.
- New staff were mentored by more experienced staff. For example, the newly qualified health visitors were mentored by more experienced health visitors whilst they gained experienced and additional training.

## Multidisciplinary working and coordination of care pathways

- Multidisciplinary working and multi-agency working was routinely practiced throughout CCHP. One example of this was a local authority initiative called First Point. The CCHP had been involved in this project since its launch in October 2013. It had streamlined the referral process into children and young people's services and managed the increased referrals to social care, and started work on early intervention. First Point brought together health and social care professionals to work in partnership in a single clinical hub.
- The specialist service for children with learning disabilities was developed as a multidisciplinary team approach that included specialist nurses, support workers, clinical psychologists and a specialist psychiatrist. The team worked closely with the Child and Adolescent Mental Health (CAMHS) team and had access to art, drama and music therapy services.
- CCHP had developed an ADHD pathway. The care pathway had been developed through a multi-professional and multi-agency approach. The care pathway was very comprehensive from the initial assessment through to a parent training programme/information-giving. As part of this care pathway, the ADHD nurse specialist was involved in training and advising schools.
- The Barnardo's Child Sexual Exploitation (BASE) project focused on young people who were at risk of exploitation. A specialist worker worked jointly between CCHP and CAMHS. The project focused on increasing awareness of child exploitation. Staff worked with young people who had been exploited and looked for vulnerabilities that could lead young people to be exploited. The project work accessed CAMHS, CCHP and Barnardo's, and had a very close working relationship with other agencies. This service was seen as innovative because of the way the service had been integrated into CCHP. CAMHS and Barnardo's, and had instant access to other agencies to make sure the safety of children and young people. At the time of our inspection, the service was reviewing how to evaluate its effectiveness. The increase in demand the service had seen was a result of the successful way the project worked with other agencies. We did see evidence that suggested the project was successful and that demand had increased.
- The health visitor and school nursing teams worked in partnership with others on a daily basis, including GPs, social services, midwives and schools.
- Strong multi-professional and multi-agency working was a focus within the CCHP. We saw evidence that meetings and participation groups took place to look at ways to collaborate in improving services for children and young people. These meetings took place with staff from children's social care, adult social care, education, commissioners and the CCHP.





# 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

During our inspection we saw many examples of extremely caring staff and how well they interacted with children, young people and their families. This view was reinforced by the people we spoke with during our inspection. All the feedback we received from children, young people and their families was consistently positive. The ethos of family-centred care was visible across all the teams within the Community Children's Health Partnership (CCHP). Children and young people were full partners in their own care, and the collaboration with Barnardo's meant innovative ways were explored to increase participation and improve care.

## Compassionate care

- We received exceptionally positive feedback from children, young people and parents. Some of the comments given to us by young people and parents included "the staff have been really good to me" (young person). "The staff look after us and it's good to know you're not alone" (young person). "The staff are great and I feel like they are going to help me" (young person). "This is simply the best service, they truly listen to what I have to say" (parent). "I am pleased that appointments are so flexible and they provide my child with any equipment when they need it" (parent).
- We observed excellent interactions and communication between staff and children and young people, and their parents or carers. Staff were skilled in caring for children and young people, and their approach was relaxed and caring. They demonstrated that children and young people were always at the heart of everything they did, but perhaps more importantly they actively listened to them and acted in accordance with their wishes.
- We observed several clinics that showed the good rapport staff had with children and young people. Staff were sensitive and in one example offered helpful strategies to manage emerging challenging behaviours in adopted children.
- Staff were experienced in responding to non-verbal communication from young children and were able to change their approach accordingly to make them feel as comfortable as possible. The parents we spoke with during this inspection all confirmed these positive interactions.

- We spent time on home and school visits with the health visitors and school nurses. Health visitors were responsive and aware of their clients' past and present history and of any impact that this might have on their current care. We observed a lovely manner that a school nurse had with a child and family when dealing with a sensitive issue.

## Dignity and respect

- Staff treated children, young people and their parents or carers with dignity and respect. We observed this both in clinic settings and when visiting people at home. For example, staff removed their shoes when entering a private house and respected the home owner's wishes.
- Within each clinical hub, family support workers were able to support families in various situations. One example was running a support group for mums with children with disabilities. This support group focused on one part of the community where traditionally disabilities were seen as something that should not be talked about. This helped to educate mothers and break down some of the cultural barriers.
- Staff had excellent links with local community leaders, such as local religious leaders, and the Somali community. Staff had undertaken specific work to further identify issues within a community, such as 'Understanding child play and development in Somalia and Bristol'. This work had been shared with other agencies to raise awareness among professionals of the varying perceptions of safety, social connections and support.
- The children, young people and parents all told us how staff treated them with respect and dignity.
- Staff had received additional training through the clinical governance meetings on bilingualism and cultural diversity. This raised awareness of multi-cultural issues and shared good practice.

## Children & young people understanding and involvement

- The learning disability team produced a range of different information leaflets on autism aimed at staff, parents and children and young people to promote understanding and involvement. These leaflets included



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

helping parents with their child's autism, managing signs and symptoms of ADHD, techniques for calming down and refocusing activity in securing good behaviour. This information was very comprehensive.

- One particular leaflet was specifically for children and young people. The leaflet had been produced with the involvement of children and young people themselves and as such used suitable words and pictures so that it could be easily understood.
- Parents told us "my son feels like we can move forward now and is able to get any questions answered, my son felt informed because the doctor spoke to him as well as me" (parent). "The assessment was thorough, clear explanation and felt they left no stones unturned" (parent).
- In another example, we saw that children who attended the health assessment for looked-after children received their own letter that had been designed by children. The letter was personal to each child and thanked them for coming to their assessment and gave them suggestions on how to stay healthy. This was based on discussions that the child and doctor had during the assessment.
- Participation with children and young people was routinely undertaken throughout CCHP. Comments from young people and parents about how this had improved outcomes for them included: "Being involved has improved my communication skills with others; I get treated as an equal" (young person). "When I was younger I was a difficult person to be with, I thought the whole world was against me, but now doing this has given me responsibility and respect and I have changed" (young person). "You feel valued and they really do seem that they want to take your ideas on board" (parent). "I feel like I am making a difference because my opinions mattered to the professionals" (parent). "People really wanted to listen to me and learn from me" (young person).

## Emotional support

- A range of training sessions were arranged in Bristol and South Gloucestershire, such as 'Why and how by thinking aloud'. This was a training session for foster carers and adopters that would build knowledge and understanding of attachment, which in turn would help them understand and change the behaviours of the children they cared for.

- We observed staff provided initial emotional support for children and young people and for their parents or carers. Additional support was provided for parents to enable them to support their children with their emotional needs. For example, in a clinic appointment, the paediatrician provided a lot of support to parents whose child was experiencing challenging behaviour. By supporting the parent in this way, the parent was better equipped to manage their child's behaviour at home.
- School nurses ran drop-in clinics at secondary schools around Bristol and South Gloucestershire. These drop-in sessions enabled young people to get emotional support on any issues that worried them.
- Within the Be Safe programme, young people and their parents told us how mentally and emotionally draining some of the sessions were. The staff were aware of this and provided skilled emotional support. This support was provided individually, but also within a family group session.

## Promotion of self-care

- All the different teams within the CCHP promoted self-care for the children themselves, when appropriate, and for parents to enable them to promote healthy lifestyles for them and their children.
- An excellent example of this was through the Be Safe programme. Children and young people were taught 'turtle steps' as part of the programme. These steps encouraged self-awareness of their emotional needs by getting them to stop and say how they were feeling, go into their shell to relax and think what would happen if they took a course of action and what they could do instead. Finally 'turtle steps' encouraged them to pick the best thing to do and do it. These steps were available to the children and young people in leaflet form, but staff had also prepared small key-ring versions so they could be kept handy and referred to as necessary.
- Another example to promote self-care and personal safety was the Stay Safe Net programme. This was the only initiative of its kind in the South West and focused on young people aged eight to 17 years who might be at risk of grooming on the internet.



# 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

The Community Children's Health Partnership (CCHP) was responsive to the needs of the local communities of Bristol and South Gloucestershire, but also responsive to individual needs within those communities. The needs of children and young people were central in the planning of any service within CCHP and this was done in conjunction with other agencies and working in partnership with them for the benefit of children and young people.

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

- The CCHP met the needs of the community as a whole, but also met the needs of different people within that community. One example of this was seen with the Gypsy, Roma, Traveller (GRT) team. This was a multi-agency approach to improving the outcomes for the GRT community. This approach meant that GRT children and families received the right help in the right place at the right time. The team recognised the specific health needs of a nomadic community and arranged to visit them wherever they were in Bristol.
- Other examples included specialist clinics for adopted children that were held at different locations to avoid possible contact with birth parents. In another section of the community, families missed a lot of appointments because they didn't use diaries. Family support workers now contact these families directly to remind them about their appointments.
- School nurses ran drop-in clinics in secondary schools. Any pupil can attend at any point, to discuss anything, including alcohol, drugs, growing up, bullying.
- An innovative approach was taken with the Somali community because of specific issues that had been identified with this community, such as not attending appointments. A family support worker was employed who liaised with the Somali families and the health visitors or school nurses to make sure the children got their appropriate checks and immunisations.

## Access to the right care at the right time

- The Be Safe programme ran a number of different programmes. The needs of each child, young person and their families were assessed so that they could

access one or more of the appropriate programmes. This showed the flexibility and adaptability of the service in meeting the needs of each individual child and young person. After referral, children and young people were usually seen for treatment within six weeks. This time included discussions about the referrals, an assessment and a multi-agency meeting that included parents.

- The participation project had also had more measurable outcomes, such as reducing the 'did not attend' rate for clinics by 40% in some areas. They achieved this by working with children, young people and their parents to look at why they did not attend clinics. Measures were then put in place to address this and make services more accessible.

## Discharge, referral and transition arrangements

- Within the Be Safe programme, because of the work the children did in their one-to-one and group sessions, discharge was referred to as 'graduation'. The children and young people graduate from the programme. This was something the young people looked forward to and was celebrated, with certificates providing the young people with a sense of achievement.
- The ADHD pathway includes transition arrangements for when the young person reached 17. These transition arrangements were planned with the young person well in advance of their seventeenth birthday to make sure they were able to ask any questions and relieve any anxieties they might have.
- Young people leaving care were given a health passport to enable them to register with a GP in their own right. Young people were supported to complete this passport by the CCHP and Barnardo's staff. This encouraged the young people to take responsibility for their health and gave them encouragement.

## Complaints handling (for this service) and learning from feedback

- The CCHP had systems in place for children, young people and their parents or carers to raise their concerns or complaints. Information on how to provide their feedback was displayed in all the locations we visited during our inspection.

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

- Staff were aware of actions to take when concerns were raised. This included trying to resolve any problems as they were raised. Staff were proactive in working in partnership with children, young people and their families, which minimised the need for people to raise complaints. If there were complaints, staff knew what to do and how to signpost people to the complaints procedure if they could not resolve concerns locally.
- We examined the complaints report for 2013 and 2014. This showed that 31 complaints had been received across the CCHP. The report showed the complaints broken down into area and profession. Themes were identified and any learning from a complaint was detailed. For example, rolling out 'how to be heard' across all clinical areas so that feedback from young people and their families was acted on locally using the principles of 'you said, we did'. This method had proven effective in informing service development and reducing the number of complaints being received.
- Minutes of governance meetings showed us that the CCHP staff discussed complaints in detail. For example, one complaint initially appeared to be about poor communication. Staff identified that it was more complex than 'just poor communication'. Detailed analysis found the parents felt blamed by staff in a safeguarding process. Once this had been identified, staff were able to understand how communication was sometimes perceived and allowed them to change.



# 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

The Community Children's Health Partnership (CCHP) was extremely well-led at all levels, from individual teams within a clinical hub to the specialised programmes offered and the overall management of the service. The CCHP was well on its way to achieve its aim to work in true partnership by working with Barnardo's and children and young people. It was a model that was unique in the country and an exemplar of good practice for other teams to follow. Working in partnership with other agencies and professionals routinely happened within CCHP Joint managerial meetings took place regularly with CCHP staff and Barnardo's staff, and the relationship was respectful and close, with constructive challenge.

## Vision and strategy for this service

- The CCHP children and young people's participation strategy 2014 – 16 had been developed by a group of young people in conjunction with the CCHP and Barnardo's staff and this work was supported by a researcher from the University of the West of England, who was doing a PHD on embedding children and young people's participation in health and social care. They formed their own strategy group and took the lead on the strategy across the trust. This showed true commitment from the trust to hearing from young people themselves and to make sure their voice was heard. The strategy set out the CCHP's vision and expectations of what 'good participation' looks like. This initiative formed part of the wider North Bristol NHS Trust patient experience strategy.
- The ambition of CCHP was to establish participation as an everyday process, which was understood, valued and acted on by professionals and children, young people and their parents or carers. This participation was undertaken routinely in everything staff within CCHP did from policy development through to interviewing. The CCHP managers told us that the next challenge would be to extend this across North Bristol NHS Trust.
- The strategy was under review, looking at what had been achieved and what they wanted to achieve in the future. They had achieved an integrated service,

delivered in the local community that was strong with participation. The child population in Bristol and South Gloucestershire was growing and they needed to review services to manage that increase.

- The CCHP managers were aware of the potential challenges ahead, including the need to benchmark clinical services.

## Guidance, risk management and quality measurement

- The CCHP had robust systems in place for risk management and governance. We examined clinical governance reports. These were comprehensive.
- The risk register showed the risks that had been identified, as well as the consequences if they were left unresolved. Each risk was given a risk rating using the scoring system recommended by the National Patient Safety Agency. A manager was allocated to oversee the risk and the actions plan that was associated with it. The register was comprehensive. For example, one risk detailed compatibility issues between the information systems of the trust and those of the local authority. The actions included new laptops for staff and interim business continuity plans while a full technology solution was developed.
- Each area such as the clinical hubs had their own multi-professional governance group. Each governance group fed into the CCHP governance committee, which in turn fed into the women's and children's and overall trust-wide governance committees. We saw evidence from minutes that confirmed this. The minutes showed a range of issues were discussed, such as complaints and compliments, rotas, policies and guidelines.
- Staff were aware of how the governance structures and how the committees reported through to the trust board.
- The CCHP held clinical governance programmes. These were six half days throughout the year that were centrally supported. Clinical staff were encouraged to attend. The programme included participation, learning lessons from safeguarding, serious case reviews, transition planning, risk assessments and clinical pathways.



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

- A quality improvement and clinical audit programme had been established. Minutes showed this was reported to the commissioners on a regular basis. The audits ranged from the school nurses' engagement with safeguarding conferences through to the experiences of Somali families in the assessment process for autism-spectrum conditions.
- School nurse drop in clinics were working towards Young People Friendly accreditation, some had achieved this. There was a schedule in place to achieve full accreditation for all school nurse drop in clinics in senior schools. This stemmed from the Department of Health's 'You're welcome' initiative. Quality standards had to be achieved in order to gain accreditation.
- A safeguarding children audit plan, led by the Safeguarding children operational group was in place. The audit programme was agreed and shared with the commissioners. This programme was comprehensive and ranged from multi-agency communication in safeguarding through to the quality of transfer arrangements from midwives to health visitors. Reports from the audits were completed, together with action plans. These were actioned and reported back to the commissioners.
- The CCHP held strategy group meetings regularly. Minutes of these meetings showed integration of services for children and young people were discussed with commissioners and local authorities.

## Leadership of this service

- At the time of our inspection, a management restructure consultation was underway. The purpose of this restructure was to improve lines of accountability, clarity of responsibility, communication and the need to reduce duplication.
- The CCHP had investment and support from the executive team at North Bristol NHS Trust about five years ago, and this was strong. As time progressed and the CCHP became more established, this support had reduced. The CCHP managers saw this as a positive move because they had established a successful service and therefore felt they didn't need as much overriding support from the trust executive.
- Staff were aware who the non-executive link was for the CCHP, and were complimentary about the interest and commitment shown by the director of nursing and the chief executive.

- Staff told us they felt well supported by their immediate managers and those within the CCHP, and confirmed they had good access to supervision.

## Culture within this service

- The culture of the CCHP was totally child, young person and family centred. Through strong participation, it had the voice of children and young people at the heart of what staff did.
- Staff told us how proud they were to be able to listen to the voice of children and young people.

## Public and staff engagement

- The Helping Young People Engage (HYPE) project was run by Barnardo's. Project workers were aligned to the two local authority areas in Bristol and South Gloucestershire as part of the CCHP. This partnership was unique and was being observed by senior researchers, government and health organisations across the country. The partnership was about bringing together the skills and experience of Barnardo's and North Bristol NHS Trust to address inequalities in health provision to improve outcomes for all children and young people and their families, especially the most vulnerable, and to have children's experience at the centre of decision making.
- The HYPE project worked in collaboration with managers, clinicians and health staff to support the involvement of children and young people and highlight their views and experiences so that whenever possible they are acted on.
- Between April 2009 and July 2012 the project worked with 400 children, young people and parents. The project supported and promoted children's involvement by:
  - Information – children have worked with project staff to develop or modify existing leaflets, letters and publications so they are accessible for children and young people. Multi-media information such as film and websites have been developed so that young people are better informed, reassured and prepared for their involvement with services in the CCHP.
  - Recruitment – young people have been provided with training and support to participate in the appointment of CCHP staff. Young people have interviewed



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

candidates independently from the professional panel, they developed their own questions based on the job description and person specification, and used their own experience of receiving health services.

- Participation training – young people and parents were trained and supported to co-facilitate this training with HYPE workers and included input from clinicians.
- Complaints – one HYPE worker was attached to the North Bristol NHS Trust advice and complaints team to develop an accessible complaints service for children and young people. This included dedicated information for young people on informal and formal complaints.
- Children and young people who were involved in the health assessments for looked-after children completed surveys (14 children aged between 4 and 17 years responded). The latest results showed that 100% of those who responded were happy with where they were seen and that the doctor or nurse they saw was friendly. When asked if staff explained things and listened, the children and young people again responded very positively. This survey will be repeated annually.
- 'You're welcome' and 'Young people-friendly' – the Department of Health's 'You're welcome' tool kit had been adopted but renamed 'Young people-friendly'. It was a quality standard to improve accessibility and acceptability of health services for young people. The HYPE project supported services with the assessment tool processes by planning and generating evidence and service improvement with direct input from young people through group work and young people's art to improve the clinic environment.
- A service user charter had been developed. This had been produced by a group of young people aged 14 to 20 years who developed a six-point service user's charter. This was adopted and was used widely across the CCHP. It had also been made into a DVD. The charter stated that children and young people:
  - Should have a say in what information is shared and with whom.
  - Should have a say in arranging their appointments, in places that are clean, comfortable and accessible.
- Special feedback forms were available across the CCHP. These were aimed at children, and the format of these forms was suitable for their age group. The forms asked what they were happy with, what they were not happy with and what would make it better for them. Comments were responded to using the 'You said, we did' boards that were on display across the CCHP. The boards highlighted the comments that had been made and what CCHP had done about them.
- Reference packs were available to managers and clinical teams as necessary. These packs gave them useful resources on getting started with participation.
- A unique example of participation was the inclusion of young people on interview panels. The young people were given mentoring and preparation training. We talked with four young people who were just about to interview six candidates. They told us that they each asked a question, scored each candidate and gave their reasons for their scores. They told us they had received training on interview techniques. We saw that the scoring from the young people represented 50% of the overall score for each candidate. This demonstrated that the views of the young people were taken seriously. This was supported by what the young people told us. They felt proud that they were able to have their say as to who was and who wasn't employed in services that affected young people. Monitoring that had been done following interviews showed that 100% of both professionals and young people felt the young people had significant influence in the final decision for recruitment of new staff.

## Innovation, improvement and sustainability

- A pilot transferring some attention deficit hyperactivity disorder (ADHD) services to a nurse led model had demonstrated improved quality and reduced costs. Plans were in place to monitor the service to look for adverse events and supervision arrangements to ensure it was safe. Overall satisfaction with care indicated that parents were just as satisfied with the care under the combined doctor and nurse-led service as they were with a solely doctor-led service. Parents who had not experienced the doctor-led service all gave top ratings



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for overall satisfaction with care. Comments from parents included “I felt that my son and I had excellent care when we have been visited by the nurse, her knowledge and understanding have been a great help to me, which in turn helped our whole family”. “The nurse at times has been our lifeline”.

- The ADHD specialist nurse service was unique and an example of good practice. The nurse provided parental support, liaised with schools to increase awareness and training, liaised between the CCHP and the adolescent mental health services and worked in partnership with Barnardo's. It was a service that parents could contact directly for advice.
- School nurses ran drop-in clinics in secondary schools. Any pupil could attend at any point, to discuss anything, including alcohol, drugs, growing up, bullying.
- An innovative approach was taken with the Somali community because of specific issues that had been identified with this community, such as not attending

appointments. A family support worker was employed who liaised with the Somali families and the health visitors or school nurses to make sure the children got their appropriate checks and immunisations.

- Six pupils from a primary school received training from the HYPE project. These pupils then went on to successfully recruit a school nurse for their school.
- The CCHP had won numerous awards for its work with participation with children and young people and for its partnership with Barnardo's. These awards included winner of the NHS South West Regional Awards 2013 for learning difficulty specialist service in category of inclusion. The CCHP was a finalist in the annual Health Service Journal awards 2012 for redesigning its services for children and young people in conjunction with Barnardo's.
- The Be Safe programme was a unique service in the country with regards to the specific service they provided. Staff from the programme have had articles published and had presented their work at national conferences.