

5 Boroughs Partnership NHS Foundation Trust

RTV

# Community health services for children, young people and families

## Quality Report

Hollins Park House, Hollins Lane, Winwick

Warrington, Cheshire, WA2 8WA

Tel: 01925 664000

Website: <http://www.5boroughspartnership.nhs.uk>

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
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This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust

# Summary of findings

## Ratings

Overall rating for the service		Good	●
Are services safe?		Good	●
Are services effective?		Good	●
Are services caring?		Good	●
Are services responsive?		Good	●
Are services well-led?		Good	●

# Summary of findings

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# Summary of findings

## Overall summary

We gave the community health services for children, young people and families an overall rating of good.

The level of incidents reported show low risk of harm and safe systems for care and treatment of patients. Staff understood how to report incidents. There were processes in place to help staff provide patients with safe care and support in clean and suitably maintained premises. There were enough staff with the right mix of skills to meet patients' needs.

The community health services provided effective care and treatment that followed national clinical guidelines. Staff knew how to use care pathways effectively. The services participated in national programmes, such as the healthy child programme.

Most patients experienced positive outcomes following their care and treatment. However, breastfeeding initiation and six week continuation rates were below national averages. The services planned to improve compliance through engagement at baby clinics and breastfeeding peer support sessions, and through raising awareness of these services.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. However, the immunisation team did not always apply the Gillick

competency principles when providing treatment for young people in special schools and routinely sought consent from their parents or carers instead of identifying whether the young person had the capacity to consent.

Patients' relatives spoke positively about the care and treatment provided by staff. Staff treated them with dignity and compassion. Staff kept patients and their families or carers involved in their care. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for staff, patients and their relatives or carers.

Services were planned and delivered to meet the needs of local people. Complaints about the service were shared with staff to aid learning. Most patients received care and treatment in timely manner. However, the trust target to treat patients within 18 weeks of referral was not always achieved by the speech and language therapy and occupational therapy / physiotherapy teams. A service transformation plan was in place to improve the delivery of services.

The trust vision and values had been cascaded and staff understood them. There was clearly visible leadership in place through local team leaders and business managers and staff were positive about the culture and support available. Routine meetings took place to review incidents, key risks and monitor performance.

# Summary of findings

## Background to the service

The children's, families and wellbeing services provided by 5 Boroughs Partnership NHS Foundation Trust consisted of the universal child health service and the targeted and specialist service.

The universal child health services offered a universal (access for all) programme of screening and health promotion services across the Knowsley area. These included health visiting, school nursing, special school

nursing, family nurse partnership, breastfeeding peer support and immunisation. These services were provided by six local teams consisting of two teams each covering the north, central and south Knowsley localities.

The targeted and specialist service consisted of speech and language therapists, physiotherapists, occupational therapists and support workers. These teams provided targeted services across Knowsley and St. Helens for children and young people that had been referred to the service.

## Our inspection team

**Chair:** Kevin Cleary, Medical Director

**Head of inspection:** Nicolas Smith, Care Quality Commission

**Team Leaders:** Lorraine Bolam, Care Quality Commission

The team included two CQC inspectors and a variety of specialists including a health visitor, a paediatric nurse and a school nurse.

## Why we carried out this inspection

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

## How we carried out this inspection

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 hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 21 - 24 July 2015. During the visit we held a focus group with health visitors that worked within

the service. We visited the community teams at Manor Farm Primary Care Centre, St. Chads Centre, Towerhill, Anita Samuels Centre, the Robins Children's Centre, Bluebell Park Special School, and the North Huyton and Whiston team offices.

We observed how people were being cared for and talked with carers and/or family members of 14 people who use the services. We reviewed the care or treatment records of 16 people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We spoke with a range of staff including nurses, therapists, support staff, business managers and the safeguarding lead nurse for children's community services.

# Summary of findings

## What people who use the provider say

The relatives of the patients we spoke with were positive about the care and treatment delivered by staff. They told us staff provided compassionate care and that they were kept involved in their care and treatment.

## Areas for improvement

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

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

- Improve compliance with the lone working policy so risk assessments are completed appropriately.
- Improve compliance with consent policies so Gillick competency and Fraser guidelines are used effectively.
- Improve performance against the 18 week referral to treatment standards for therapy services.
- Reduce the number of patients that 'did not attend' scheduled appointments or sessions.

# 5 Boroughs Partnership NHS Foundation Trust

## Community health services for children, young people and families

**Detailed findings from this inspection**

**Good** 

### Are services safe?

By safe, we mean that people are protected from abuse

#### Summary

The level of incidents reported showed low risk of harm and safe systems for care and treatment of patients. Staff understood how to report incidents. There were processes in place to help staff provide patients with safe care and support in clean and suitably maintained premises. Patient records were complete and accurate. There were enough staff with the right mix of skills to meet patients' needs.

#### Safety performance

- The strategic executive information system data from May 2014 to April 2015 showed there were no serious incidents reported in relation to the children's, families and wellbeing services.
- Trust records showed there had been 177 incidents reported across the services between July 2014 and June 2015.

- This included 104 patient-related incidents, of which nine incidents led to patient harm and were reportable to the National Reporting and Learning System.
- The service performance report showed there were three patient falls with harm, no catheter urinary tract infections and no new pressure ulcers reported between July 2014 and June 2015.

#### Incident reporting, learning and improvement

- Staff were familiar with the reporting systems for incidents and all staff had access to the trust-wide electronic incident reporting system. All incidents, accidents, complaints and allegations of abuse were logged on the electronic incident reporting system.
- Team leaders reviewed and investigated any incidents logged on the system to look for potential improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the business managers.



## Are services safe?

- We saw evidence that incidents were investigated and remedial actions were implemented to improve patient care. For example, the process for administering medicines at a special school (for children with complex needs) was changed following a medication administration error so that two trained nurses gave medicines at all times.
- Staff told us incidents and complaints were discussed during weekly allocation meetings and at monthly staff meetings, so shared learning could take place. We saw evidence of this in the meeting minutes we reviewed.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. Staff were able to give examples where the parents of patients were informed following a medication error and following an incident where documents were filed in the wrong patient records.
- There were policies in place to provide staff with guidance on prescribing, handling and storing medicines, including vaccines.
- Health visitors authorised to prescribe medicines followed local prescribing procedures that included specific guidance for prescribing medicines for pain relief, treatment of head lice and skin moisturising creams for children and young people.
- We saw that vaccines were securely stored in locked fridges and kept at temperatures between 2°C and 8°C. Fridge temperatures were monitored daily. There were clear instructions for staff to follow if fridge temperatures exceeded acceptable temperature ranges.
- The immunisation team carried out routine checks of medication stocks to ensure that vaccine stocks were reconciled correctly and were within their expiry dates.
- We observed two nurses carrying out medication rounds at a special school and found there were safe systems in place. The nurses checked the medication and verified the identity of the patient before giving medication. The administration records were countersigned to minimise the risk of errors. Staff wore red aprons so they could be easily identified while carrying out medication rounds.

### Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. The safeguarding children and safeguarding adults' policies provided further guidance for staff.
- Records showed 86% of staff had completed their training in safeguarding children and 82% had completed safeguarding adults training.
- Staff understood how to identify abuse and how to report safeguarding concerns. The safeguarding children and adult's service annual report 2014/15 showed 33 referrals were made to the children's social care service following the identification of safeguarding concerns by community health staff between April 2014 and March 2015.
- Staff received quarterly supervision specific to safeguarding, so they could discuss the safeguarding issues in their caseloads and receive additional guidance and support from the safeguarding children team.
- Safeguarding processes and incidents were reviewed by a trust-wide safeguarding committee, which held meetings every two months. The safeguarding lead for children's services also reviewed safeguarding incidents to look for trends and this information was shared with staff through monthly team meetings.

### Medicines

### Environment and equipment

- There was appropriate equipment in each of the clinics, including arrangements for managing and disposing waste. The clinic areas we visited were well maintained, free from clutter and provided a suitable environment for treating children and young people.
- We saw that children's toys used in the clinics and other activity items used by the therapists were age appropriate, clean and well maintained. Staff told us they used sterile disinfectant wipes to clean and decontaminate equipment.

## Are services safe?

- Community staff, such as health visitors, routinely used equipment such as portable scales. Scales and other equipment were also used in clinic settings. We saw that the scales were regularly serviced and calibrated.
- Staff told us they always had access to the equipment and instruments they needed to meet patients' needs.

### Quality of records

- The children's, families and wellbeing services used both electronic and paper-based patient records. During the inspection we looked at paper and electronic records for 16 patients. These were structured, legible, complete and up-to-date.
- The service used an electronic records system for recording patient contact details, letters received and sent, and for evaluating care plans. Paper records were used to record activities during community and home-based visits. Staff on community visits wrote details on paper records and then updated the electronic system later in the day. This meant there was a potential risk of transcription errors when staff updated the electronic record.
- Paper-based patient records were stored securely in the team office bases and there were effective systems in place so these records could be accessed and retrieved in a timely manner.
- There was an annual records audit to monitor the quality of patient records. The audit report for March 2015 was based on a sample of 241 records from across the children's, families and wellbeing services. The records audit demonstrated that patient records from across the services were completed and maintained to a good standard.
- The audit showed in over 90% of cases there was documented evidence of an up-to-date plan of care, in 85% of cases care was delivered in accordance with that plan, and in over 82% of cases, this was discussed and agreed with the patient or carer.
- The audit showed that in over 81% of cases discussions had taken place regarding the patient's expectations/wishes with regards to outcomes. In over 86% of cases where a risk assessment was required there was documented evidence this had been undertaken. In 57% of cases, there was documented evidence that patients were seen by a member of staff. In over 79% of cases, there was documented evidence that the patient or carer had given informed consent.
- The audit also highlighted two areas where further improvements in basic record keeping were needed: the use of abbreviations that complied with agreed lists and seeking permission from the patient or their carers to share information.
- Babies and younger children attended drop-in wellbeing clinics where they brought their own personal child health records or "red books" with them. This is a book given to parents at the birth of a child to record observations and outcomes from any clinics they attend, as well as to record immunisations. We looked at the red books for nine patients and found these were not always fully completed following staff interventions.

### Cleanliness, infection control and hygiene

- Staff were aware of current infection prevention and control guidelines. The areas used for seeing children and families were clean, tidy and well maintained. There were adequate hand washing facilities for staff and patients in the clinic settings.
- We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff visiting patients in the community had access to portable hand gels and personal protective equipment, such as gloves, if needed.
- We saw there were signs advising patients, families and staff to wash their hands. There was also hand gel available for patients and families throughout the areas we visited.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Staff used sterile disinfectant wipes to clean and decontaminate equipment, such as weighing scales, as well as other areas of the general environment (e.g. furniture) where patient contact had taken place.
- There were infection control link nurses in place who cascaded information from the trust-wide infection control team and provided advice and support to staff within their teams.
- The infection control team carried out a bi-annual audit to monitor hand hygiene, 'bare below the elbow' compliance and cleanliness of the general environment across the clinics and walk-in centres used to provide care for patients. The audit report showed that during 2014/15 compliance was at least 90% in all areas. Four health centres had initially failed to achieve the 90% compliance target; however, these were re-audited and found to be compliant.

# Are services safe?

## Mandatory training

- Staff received annual mandatory statutory training, which included key topics, such as infection control, fire safety, safeguarding children, safeguarding adults, basic life support, and moving and handling.
- Staff also received mandatory core training, which included key topics such as equality and diversity, promoting safe and therapeutic services, information governance and health and safety.
- Records up to June 2015 showed that 82% of staff across the children's, families and wellbeing services had completed the statutory training and 89% had completed the core training. However, this was below the trust's internal target of 90%.

## Assessing and responding to patient risk

- Staff completed patient risk assessments as part of an initial assessment. These highlighted patients with specific health needs and identified patients at risk of harm.
- Patient records demonstrated that staff monitored individual patients through the 'use of nursing care' pathways, which they used effectively. Health and safety risk assessments were in place for areas such as treatment rooms and clinics.
- Issues relating to patient safety were routinely discussed at multidisciplinary staff meetings within each team. Where staff identified patients as being at risk, actions were taken such as referral to medical or other healthcare professionals.

## Staffing levels and caseload

- Staffing levels and caseload mix within the community health services were based on the Royal College of Nursing (RCN) standards for safe staffing levels for children and young people's services. The services conducted a health equity audit at least annually to monitor staffing levels in response to any increase in safeguarding cases. This was part of the national health visitor recruitment campaign, 'a call to action', which is a national plan to increase the numbers of health visitors nationally by the end of 2015.
- The areas we inspected had sufficient numbers of trained nurses, therapists and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.

- There were 45.01 whole time equivalent (WTE) health visitors in post in June 2015, which was better than the target of 44.7 identified as part of the national health visitor recruitment target.
- During June 2015, there were 14.01 WTE vacancies across the service, of which 10.7 WTE posts had been recruited to. The new recruits were awaiting start dates. The service also planned to offer permanent employment to four student nurses that were currently working within the teams.
- The average caseload size for health visitors varied, but the service was meeting the minimum RCN standard recommendation of one health visitor for every 300 children under five years old.
- The caseload size for school nurses was meeting the minimum RCN standard of one school nurse for each secondary school and its cluster of primary schools.
- All band 6 health visitors and school nurses had achieved specialist community public health nursing (SCPHN) qualifications. Band 5 nurses carried caseloads that included vulnerable children and young people. Staff with caseloads that included vulnerable children (e.g. child protection or looked-after children) received Local Safeguarding Children Board's level 3 training.
- The service did not use agency staff. Cover for staff leave or sickness was provided by the existing team. The service had recently set up a bank made up of the existing nursing teams, but this was not widely used.

## Managing anticipated risks

- All staff we spoke with were aware of the process for escalating risks and concerns to their line managers. Key risks, such as staffing issues, were discussed during weekly planning and allocation meetings.
- There was a policy in place to support lone working and this included instructions for staff on how to maintain their safety when carrying out lone visits to patients' homes. Staff were required to complete a risk assessment before carrying out a visit for a new referral where safeguarding or potential domestic abuse and violence risks had been identified. However, we found that these risk assessments were not always completed by staff.
- Staff told us they had mobile phones and operated a buddy system so their whereabouts were known and to allow them to contact the team base if they encountered any issues during lone visits.

## Are services safe?

### Major incident awareness and training

- There was a documented business continuity plan and risk assessment in place specific to the teams providing children's, families and wellbeing services, and this provided instructions for staff on how to manage key risks that could affect the provision of care and treatment.
- There were clear instructions in place for staff to follow in the event of a fire or other major incident, such as the loss of electronic systems.
- Staff received mandatory training in fire safety and health and safety. Records up to June 2015 showed 73% of staff across the children's, families and wellbeing services had completed basic life support training.

# Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Summary

The children's, families and wellbeing services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national programmes such as the healthy child programme.

Audit records showed most patients experienced positive outcomes following their care and treatment. However, breastfeeding initiation and six week continuation rates were below national averages. The services planned to improve compliance through engagement at baby clinics and breastfeeding peer support sessions, and also to raise greater awareness of these services.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. The immunisation team did not always apply the Gillick competency principles when providing treatment for young people in special schools and routinely sought consent from their parents or carers instead of identifying whether the young person had the capacity to consent.

## Evidence based care and treatment

- Care and treatment was evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- We saw care pathways for immunisation, integrated complex needs, healthy child programme, language pathway, maternal health, antenatal care, post-natal care and breastfeeding peer support that were used by staff and these were based on nationally recognised standards.
- The universal child health services participated in national programmes such as the Healthy Child Programme and the National Child Measurement Programme.
- The breastfeeding services were accredited by the Unicef UK Baby Friendly Initiative and they conducted an annual audit to maintain the accreditation.

- Staff participated in local audits to assess how well guidelines were adhered to. Local audits included the annual audit form for health visiting and public health nursing services, pilot of new universal family health needs assessment tool and the staff review of current family health needs assessment tool. Findings from local audits were shared with staff to aid learning and improve services.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at a selection of policies and procedures on the trust's intranet and these were up to date and reflected national guidelines.

## Pain relief

- The health visitors and school nurses told us they provided advice to parents and young people if they identified patients with pain symptoms. They could also prescribe pain relief medication, such as paracetamol, if needed.
- The immunisation team offered advice to parents or guardians and young people following injections on the safe use of paracetamol in case of pain or fever during the day of vaccination.

## Nutrition and hydration

- Health visitors and school nurses offered advice to children and young people on healthy eating and maintaining healthy diets. Children that were found to be in need of specialist assessment were routinely referred to the dieticians.
- Advice and support was also offered to breast feeding mothers, including providing them with equipment such as breast pumps.

## Technology and telemedicine

- There was a project in place to transfer to a new electronic patient record system (RIO) across the children's, families and wellbeing service and this was scheduled to be in place by December 2015.



## Are services effective?

- The service had created a local implementation group (LIG) to facilitate the roll out for the service and key risks associated with implementing the new system had been documented and assessed.
- Staff spoke positively about the transfer to the RIO system and told us it would address some of the issues with the existing system.

### Patient outcomes

- Records between July 2014 and June 2015 showed the service achieved trust targets for completing at least 80% of birth visits within 10-14 days of delivery and at least 70% of children had attended a two and a half year review by 30 months in accordance with the Healthy Child Programme.
- During 2014/15, 74.3% of children in reception class and 79.3% of children in year seven received a face-to-face interview with a school nurse. However, this was below the trust target of 90%. This was attributed to staffing constraints and levels of patients that 'did not attend' (DNA).
- The National Child Measurement Screening Programme, which is a screening programme for children in reception and year 6, was being effectively implemented and 99% of children in reception and 97% of year 6 children were being appropriately screened and assessed in Knowsley during 2013/14 in line with the national programme.
- The safeguarding children and adults service annual report 2014-15 showed that between April 2014 and March 2015, 154 children and young people that were identified as looked-after children (LAC) had an initial health assessment (IHA) completed which had resulted in an individual health action plan. In addition, 16 children and young people were either only looked after for a very short period and therefore did not receive an IHA or refused to participate.
- The Department of Health statutory guidance "Promoting the health and well-being of looked-after children" stated that a review of health assessments must occur once every six months for children under the age of five years and at least once every twelve months for children and young people from five to 18 years of age.
- During April 2014 and March 2015, 88.95% of looked-after children in Knowsley had a completed review health assessment (RHA) by health visitors and school nurses with LAC on their caseload. The safeguarding report highlighted there was no direct national comparison published for 2014/15 although previous comparisons indicated that this was within the best band nationally.
- Health surveillance and development checks of Knowsley looked-after children under age five years were 100% complete compared with a national average of 86.8% during this period. During April 2014 and March 2015, 95% of Knowsley looked-after children had age appropriate immunisations. The safeguarding report highlighted that in previous years this had been above the national average.
- During April 2014 and March 2015, 89.50% of Knowsley looked-after children had a dental health check. The safeguarding report highlighted further improvements could be made and the services planned to improve compliance over the next year.
- NHS England data between April and June 2015 showed the breastfeeding initiation rate in Knowsley was 47.3%, below the England average of approximately 75%.
- Trust data showed the breastfeeding continuation rates at six weeks in Knowsley were 19.3% in June 2015, compared with a target of 26.7%.
- The business manager for universal child health services told us breastfeeding initiation rates had steadily improved from 14% since 2010 following the introduction of 'bosom buddies' peer support intervention sessions and there was a continued focus on improving breast feeding rates through these sessions.
- The baby friendly initiative audit from February 2015 showed most compliance standards were being met. However, further improvements were needed following feedback from 16 breastfeeding mothers and 15 bottle-feeding mothers in relation to follow up information and advice given by staff. There was an action plan in place to improve audit compliance, including for staff to review and evaluate the findings of the audit to improve services.

### Competent staff

- Newly appointed staff had an induction which included mandatory training and shadowing an experienced member of staff for a period of time based on their training needs.



## Are services effective?

- Staff received management supervision every three months. The team leaders also carried out an annual observation visit at least once annually for each member of staff to observe clinical practice.
- Staff also received a personal development review (PDR) appraisal every three months. Records up to June 2015 showed that the majority of staff across the children's, families and wellbeing services had completed their PDR appraisal (82.3%). However, this was below the trust's internal target of 90% completion.
- The business manager for universal child health services told us the PDR compliance data included staff that were not eligible for PDR reviews, such as student nurses and that this was being addressed with the human resources team to ensure the data was accurate.
- Staff were positive about on-the-job learning and development opportunities and told us they were well supported by their line management.
- The service had a programme of workforce development that encouraged Band 5 child health nurses to progress to SCPHN qualification through secondment opportunities. The service had supported five child health nurses during the last three years in school health SCPHN training and a further five in SCPHN Health visiting. In addition, they were supporting a further two band 5 child health nurses who were scheduled to commence their training programmes in September 2015.

### Multidisciplinary working and coordinated care pathways

- There was effective communication and multidisciplinary team working within each local team. There was an integrated service provided to children aged 0-19. Staff across different disciplines, such as health visitors, school nurses and therapists worked closely as part of an integrated team and there was effective communication to ensure all staff had up-to-date information about patient risks and concerns.
- Staff worked closely in partnership with other organisations, such as the local authority, children's services, local schools, local hospitals and the Police so that information regarding vulnerable children and families was shared to support the provision of care and enable the community based staff to offer appropriate support to children and families.

- There were regular inter-agency safeguarding meetings to ensure the safety of children and families using the services.

### Referral, transfer, discharge and transition

- Children and families were referred to the services via a number of routes, including their general practitioner (GP), local hospitals and social services and through self-referral.
- Staff had processes in place for managing patients referred to the service or transferred in from out of the area where a formal handover or transfer of patient records was required before making face-to-face contact. Where children and young people transferred out of the area, staff created a transfer summary sheet that included all the relevant information about their care and this accompanied the paper patient records.
- Patient transfers within the service, such as between health visitors to school nurses for young children and the transition of young people from school nurses to adulthood were effectively managed and included transfer of records and face to face contact to ensure all the relevant information was made available.
- The service planned to provide health-visiting services for children up to five years of age by geographic boundaries rather than by GP lists by the end of September 2015. There was an action plan and risk assessment in place, which outlined the plans for the transfer of patients and records in and out of the Knowsley area.
- The transfer of all children under one year old and their siblings had been completed in July 2015. Children with safeguarding concerns were scheduled for transfer by September 2015. The GP practices and the parents or carers of patients affected by the change had been notified of the planned changes and each GP practice had a link health visitor with regular contact to ensure any concerns relating to the transfer process were addressed.
- The business manager for universal child health services told us the transfer of records was ongoing and there had been four instances where the transfer of records were delayed (out of 253 records) and this was due to documentation issues, such as incomplete transfer sheets.

### Access to information

## Are services effective?

- The children's, families and wellbeing services used both electronic and paper based patient records. The records we looked at contained all the relevant information relating to the patient. This meant that staff could access all the information needed about the patient at any time.
- Staff had access to laptops, which enabled them to access trust-wide systems remotely. However, staff informed us that sometimes connectivity issues restricted their ability to use laptops effectively.
- Staff told us the existing electronic patient records system (PARIS) used across the service was not user friendly and did not have a facility to print out a summary report of a patient record. This meant the entire patient record would have to be printed off if needed. The system did not store entries (e.g. visit records) in chronological order, which meant staff sometimes had to scroll through multiple entries before locating relevant patient information.
- Staff could access information such as policies and procedures from the trust's intranet. Staff told us they received information such as performance information and trust-wide updates via email or through routine staff meetings.
- Staff understood the processes for seeking consent before providing care or treatment. We looked at records which showed that verbal or written consent had been obtained from patients or their parents or carers.
- The level of consent required was dependant on the treatment planned. For example, consent for vaccinations for children and young people was sought in writing from parents or carers prior to treatment. Consent for treatment by health visitors and school nurses was mostly obtained verbally or as implied informal consent.
- The 'immunisation consent for children and adolescents up to age 19 years procedure' provided guidance for staff on how to obtain consent and how to apply the Gillick competency and Fraser guidelines (used to decide whether a child is mature enough to make decisions) to balance children's rights and wishes with the responsibility to keep children safe from harm.
- We found that staff in the immunisation team did not always apply the Gillick competency principles when providing treatment for young people in special schools and routinely sought consent from their parents or carers instead of identifying whether the young person had the capacity to consent.

### Consent



## Are services caring?

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

### Summary

Patients' relatives spoke positively about the care and treatment provided by staff. They were treated with dignity and compassion. Staff kept patients and their families or carers involved in their care. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for staff, patients and their relatives or carers.

### Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. We saw that the privacy and dignity of patients was maintained during face-to-face consultations and clinics. However, we observed two baby clinics where two mothers were being seen at the same time. Staff told us this was due to the large number of patients that attended these clinics. The mothers we spoke with did not highlight any privacy and dignity concerns and we saw the clinics had separate rooms available where patients could be seen privately, if needed.
- We spoke with the parents of 14 patients. They all said staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.
- The children's, families and wellbeing services participated in the NHS Friends and Family test, which asks patients how likely they are to recommend a hospital after treatment. However, the response rates were low which meant the data may not provide a true representation of the majority of patients.
- Staff across the local teams sought feedback from patients and their families by asking them to complete feedback surveys. The information was used to look for possible improvements to the services. During the inspection, we looked at a selection of patient

experience surveys, including the occupational therapy (OT) and physiotherapy team (PT) appointment times survey, St. Helens paediatric speech and language therapy service patient experience survey and feedback from breast feeding mothers as part of the UNICEF UK Baby Friendly Initiative audit.

### Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patients were allocated a named nurse to oversee all the care they received to ensure continuity of care.
- Patients' parents spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment. They told us the staff kept them involved in the care of treatment of their child. The comments received included "I can ask questions and feel the staff know what they are doing" and "I feel listened to and respected by the staff".

### Emotional support

- Patients were allocated a named nurse to oversee all the care they received to ensure continuity of care.
- Staff were able to support patients and their relatives or carers to understand their care and treatment and ensure that they were able to voice any concerns or anxieties. The patient's relatives we spoke with told us they were satisfied with the communication and level of support they received.
- Staff, patients and their relatives had access to bereavement and counselling services provided by the trust, to ensure they received appropriate support following a traumatic experience.



# Are services responsive to people's needs?

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

## Summary

Services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. Most patients received care and treatment in a timely manner. However, the trust target to treat patients within 18 weeks of referral were not always achieved by the speech and language therapy and occupational therapy / physiotherapy teams. A service transformation plan was in place to improve the delivery of services.

## Planning and delivering services which meet people's needs

- The universal child health services offered a universal (access for all) programme of screening and health promotion services across the Knowsley area. These included health visiting, school nursing, special school nursing, family nurse partnership and breastfeeding peer support. These services were provided by six local teams consisting of two teams each covering the north, central and south Knowsley localities.
- The targeted and specialist service consisted of speech and language therapists, physiotherapists, occupational therapists and support workers. These teams provided targeted services across Knowsley and St. Helens for children and young people that had been referred to the service.
- Any new patients identified or referred to the services were placed on the electronic patient record system and allocated to the relevant teams so contact could be made. Each team had an allocation list and carried out weekly allocation meetings to identify patients that required contact.
- Staff provided sexual health and contraceptive advice to young people and mothers as part of their routine consultations and provided information and leaflets on how they could access the specialist sexual health services offered by other NHS providers in the Knowsley area.
- Immunisations for children up to five years old in Knowsley were carried out by nurses employed by the general practitioner (GP) practices. The GP practices referred children that were not up to date with their

immunisations to the universal child health service immunisation team, who then carried out targeted vaccinations for children that had been scheduled for a GP immunisation appointment but had not attended or received their immunisations.

- The immunisation team also provided a number of GP practices with cover when they had no practice nurses available in the surgery to immunise for routine immunisations. The service was working with NHS commissioners to address commissioning issues such as where GP practices had referred patients to the service due to staffing issues such as holidays and sickness.
- Services such as health visiting and family nurse partnership were scheduled for transfer to local authority commissioned services during by October 2015. There was an action plan and risk assessment in place to address any issues identified. The business manager for universal child health services attended bimonthly meetings with NHS England and local authority commissioners to monitor progress.
- A continence team provided advice and support for children and their families or carers. However, staff were concerned about cutbacks to this service that may impact on their ability to provide products such as continence pads.

## Equality and diversity

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff received mandatory training in equality and diversity and had access to an interpreter if needed.
- A "building community capacity event" was held in February 2015 in the Northwood area to promote health and to display the range of services on offer. Over 240 people attended the event. The service produced a team quality assessment for equality and diversity groups and clinicians engaged in the process, and devised a service DVD for promotional purposes, which they delivered at the community event.
- The healthy child programme was managed between the health visitors and school nurses. However, an

# Are services responsive to people's needs?

antenatal contact was not being routinely offered universally. Staff told us antenatal contacts were offered to mothers identified as being at greater risk during their pregnancy or where safeguarding concerns had been identified.

## Meeting the needs of people in vulnerable circumstances

- Staff developed care pathways for perinatal health and postnatal depression based on institute of health visiting (IHV) guidelines and 48 staff had been trained to use these by March 2015.
- Each child up to one year old and every family with needs (such as a learning disability) had a named health visitor. Every child with 'looked after children' status also had a named health visitor.
- Young people were asked at health assessments whether they used alcohol, tobacco or illegal drugs and offered advice on how to access additional services that could further support them.
- Staff worked closely with other organisations such as the local authority, local hospitals and the Police so that information regarding vulnerable children and families was shared to support the provision of care and enable the community based staff to offer appropriate support to children and families.
- Records showed that between April 2014 and March 2015 the service processed and reviewed 893 records for vulnerable children and families accepted into the services with 964 being transferred out. During this period, the service also processed 600 accident and emergency notifications and 1821 notifications relating to domestic abuse incidents that Merseyside Police attend in the Knowsley area.

## Access to the right care at the right time

- The universal child health services mainly operated between 9am and 5pm weekdays. The school nursing service was provided all year round and not just during term times, so children and young people could access services out of school times.
- A number of teams, such as the breastfeeding support team, children's dietetics and the speech and language therapists provided services between 8am and 8pm over seven days. Clinics and sessions were arranged during evenings to provide children, young people and their families with access to services outside of normal working times.

- Health visitors and school nurses provided their contact details so patients or carers could contact them for information and advice. One parent told us the health visitor was not available when they tried to contact them but they received a call back at a later time.
- Staff provided care and treatment either through individual sessions or via group sessions at a variety of venues such as patient's homes, primary care centres, children's centres, schools and other community venues.
- The children's, families and wellbeing services operated an 18-week referral to treatment target
- Records showed during June 2015, the physiotherapy / occupational therapy service had 5% of referrals that were waiting over 18 weeks with the longest wait at 30 weeks. The main reason for increased waiting times was highlighted as an increased numbers of referrals to the muscular skeletal service and for those with sensory processing difficulties.
- A service transformation plan was in place to enable the services to accommodate an increased numbers of referrals to the muscular skeletal service and for those with sensory processing difficulties. This included specific actions such as streamlining referral pathways, improved training for staff and setting up paediatric muscular skeletal clinics and workshops for school teachers and other health professionals (e.g. in local gyms and fitness centres and sports clubs) in order to reduce the number of referrals to the service.
- During June 2015, the speech and language therapy service had 11% of those referrals that were waiting over 18 weeks, with the longest wait at 30 weeks. The service achieved a 12-week referral to assessment wait time for all new patients into the service, including urgent dysphagia (difficulty swallowing) referrals.
- Records showed that between July 2014 and June 2015, 100% of children referred for dysphagia were seen within 2 weeks of referral. The main reason for increased waiting times was highlighted as a permanent member of staff leaving the team, which impacted on the ability of the team to meet referral targets.
- As part of the service transformation plan, there were a number of actions to improve the quality of the speech and language therapy service and manage the increased demands on the service. This included measures such as reviewing referral pathways and offering telephone advice to patients with mild

## Are services responsive to people's needs?

conditions to reduce inappropriate referrals. The service also identified that an additional 2.8 WTE staff was required for six months to ensure there was sufficient staffing capacity.

- The service monitored patients that did not attend (DNA) their appointments. Records for June 2015 showed the overall DNA rate was 12% across the children's, families and wellbeing services, compared with a target of 5.5%.
- Each team had a local action plan to reduce DNA rates. The management of non-compliance and non-engagement procedure outlined the process for staff to follow where patients did not attend appointments.
- Staff told us they made contact with patients either by telephone or by sending at least two letters where patients did not attend. When patients with safeguarding concerns did not attend and did not respond to the letter sent by the team, this was referred to children's services.
- We saw that patient feedback was mostly positive and the feedback received had been analysed to look for improvements to services. For example, the OT/PT team analysed the 54 responses received from the appointment survey in May and June 2015 and had an action plan in place to develop more flexible appointment times, including in the evenings and on Saturdays.

### Learning from complaints and concerns

- Information leaflets were available for patients and their relatives or carers on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The parents we spoke with were aware of the process for raising their concerns with the trust.
- Records showed there had been 12 complaints raised across the children's, families and wellbeing services between July 2014 and June 2015. We looked at the records for a complaint during February 2014 and found that this had been investigated and responded to in a timely manner.
- Staff understood how to deal with complaints and told us that information about complaints was discussed during routine team meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at.
- Staff told us they had created 'patient stories' and these were presented at trust board meetings and cascaded to staff to promote shared learning and service improvement.

# Are services well-led?

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

## Summary

The trust vision and values had been cascaded and staff understood them. There was clearly visible leadership in place through local team leaders and business managers, and staff were positive about the culture and support available. Routine meetings took place to review incidents, key risks and monitor performance. The services proactively engaged with staff and the public and actions were taken to improve the services.

## Service vision and strategy

- The trust states that it aims to ensure high quality services, as demonstrated by its overall purpose: “We take a lead in improving the wellbeing of our communities in order to make a positive difference throughout people’s lives.”
- This was underpinned by a set of five values that were based on quality and excellence, feedback and contribution, listening and learning, dignity and respect and delivering commitments.
- The children's, families and wellbeing services did not have a documented strategy specifically for the service. However, the service delivery was based on the trust values and key objectives and set performance targets were based on the trust values and objectives.
- The trust purpose and values had been cascaded to staff across the children's, families and wellbeing services. These values were incorporated into objectives as part of staff personal development reviews. All the staff we spoke with had a good understanding of these.

## Governance, risk management and quality measurement

- There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address identified risks.
- During the inspection, we looked at the scheduled care divisional risk register and saw that key risks had been

identified and assessed. The risk register was reviewed and updated by the business managers and the assistant director during routine management meetings.

- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the service to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through performance dashboards.

## Leadership of this service

- There were clearly defined and visible leadership roles across the children's, families and wellbeing services. The overall lead was the associate director, who was supported by the business manager for universal child health services and the interim business manager for specialist and targeted services.
- Each local team had a team leader (band 7 nurse) in place to oversee the day-to-day running of services.
- Staff told us they understood the reporting structures clearly and that they received good support from their line managers.

## Culture within this service

- There was a positive attitude and culture within the children's, families and wellbeing services. Staff spoke positively about working for the trust. They told us that they worked well within their teams and received good support from their line managers.
- Most staff described the culture as open and supportive, and that they had been well supported and encouraged to access training and obtain qualifications to enhance their careers. However, we received some negative feedback from two health support workers (band 3) who told us the opportunities for them to develop were limited.

## Are services well-led?

- Records showed the staff sickness rate within the community universal child health teams ranged from 4.65% to 9.28% between July 2014 and June 2015. The sickness rate was 7.64% in June 2015, which was worse than the target of 5%.
- The staff sickness rate within the targeted and specialist teams ranged from 0.78% to 4.59% between July 2014 and June 2015. The overall sickness rate had been consistently below the target of 5% during this period.
- There was a policy in place to support lone working and this included instructions for staff on how to maintain their safety when carrying out lone visits to patients' homes. Staff were required to complete a risk assessment before carrying out a visit for a new referral where safeguarding or potential domestic abuse and violence risks had been identified. However, we found that these risk assessments were not always completed by staff.
- Staff told us they had mobile phones and operated a buddy system so their whereabouts were known and to allow them to contact the team base if they encountered any issues during lone visits.
- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. The trust also engaged with staff via email and newsletters.
- Staff told us that although they were a community health team within a large mental health trust, they felt included and part of the trust. A number of managers and team leaders had worked across both mental health and community health services and they understood the integrated aspect of the trust. We received a mixed response from staff about the visibility of the executive management team but we saw that two of the local teams were included in an executive 'walk round' visit during 2015.
- We saw evidence of ad hoc engagement meetings and workshops conducted to engage with staff following organisational changes and to gain feedback from them. For example, the health visitors participated in an away day and this included training and an opportunity for staff to discuss issues.

### Public engagement

- We saw evidence that the teams routinely engaged with the public to promote the services and gain feedback through a variety of methods including, social media, a breastfeeding month campaign with public events, experience based design approaches for well-baby clubs and school health drop in sessions, and feedback from reception health interviews with children (4 to 5 years) and teachers.

### Staff engagement

### Innovation, improvement and sustainability

- The staff and managers across the children's, families and wellbeing services were actively involved in improving services. Staff were aware of the key challenges to the service, such as staffing issues and the ability of the teams to deliver timely services and actions were being taken to address these risks. Staff across all disciplines spoke positively about the sustainability of services and about improvements such as the implementation of the new electronic records system.