Leicestershire Partnership NHS Trust

RT5

# Community health services for children, young people and families

## Quality Report

Trust Headquarters
Riverside House
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester
LE4 8PQ
Tel:0116 295 0816
Website:www.leicspart.nhs.uk

Date of inspection visit: 14 – 18 November 2016
Date of publication: 08/02/2017

# 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) |
|---|---|---|---|
| RT596 | Melton Mowbray Hospital | Community health services for children, young people and families | LE13 1SJ |

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

# Summary of findings

## Ratings

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

We rated families, young people and children services as good because:

- There were systems in place for reporting incidents and the service was able to demonstrate learning and sharing following incident investigations. However, staff told us they had little experience of incident reporting within the community children's services.
- Safeguarding was a high priority with regular safeguarding reviews within each area of speciality and established systems for supporting staff dealing with distressing situations.
- Staff followed infection control practices and maintained equipment through regular servicing.
- Patient records were electronic, up to date and available to the multidisciplinary team to enable an integrated approach to care and treatment.
- Staff were trained appropriately within their speciality and new staff were supported to gain experience and skills.
- Children and young people felt listened to in a non-judgmental way and told us they felt respected. We observed positive interactions between staff and children and the use of age appropriate language. The school nurses used technology to communicate with young people.
- The service employed care navigators to help families and carers negotiate their journey through the various services provided.
- There was an established five year strategy and vision for the families, young people and children's (FYPC) services and staff innovation was encouraged and supported. Staff expressed pride in their ability to work as a team and managers told us they were proud of achievements. Staff were included in service developments and involved in 'listening into action' projects for service improvement.

However:

- There was a lack of reporting and monitoring of informal complaints, meaning the service was unable to monitor and recognise themes of concern with the children's service.
- The service is not appropriately commissioned to provide sufficient school nurses to meet the standard service recommendations of one nurse per secondary school and its associated primary schools.
- The medical and senior leadership provision within the looked after children service did not meet the professional requirements outlined in the intercollegiate document for this provision.

# Summary of findings

## Background to the service

Leicestershire Partnership NHS Trust cares for patients across a wide range of services within Leicester, Leicestershire and Rutland, serving a patient population of over one million.

The community families, young people and children's service is part of Leicestershire Partnership NHS Trust and provides services in a range of locations across Leicester, Leicestershire and Rutland. These locations include care homes, community and neighbourhood centres, children's centres, health centres, hospitals, schools and nurseries. In addition, staff provided care in patients' own homes.

The service included health visiting, school nursing, physiotherapy, occupational therapy, speech and language therapy, community nursing, paediatricians, family support, looked after children service, dietetics, phlebotomy services and health promotion.

During our inspection we observed clinics, accompanied health professionals on home visits and spoke with 55 members of staff including managers, team leaders and staff working within the health visiting, school nursing, physiotherapy, occupational therapy, speech and language therapy, community nursing, family support, looked after children and dietetics services. Additionally we spoke with 15 parents and carers, ten young people and children and were able to attend a children in care council meeting for looked after children transferring into adult services.

## Our inspection team

Our inspection team was led by :

**Chair**: Dr Peter Jarrett

**Team Leader**: Julie Meikle, Head of Hospital Inspection (Mental Health) CQC

**Inspection Manager**: Sarah Duncanson, (Mental Health) CQC and Helen Vine (Community Health Services) CQC.

The team which inspected this core service included CQC inspectors and a variety of specialists including: a specialist looked after children's nurse, dietician, speech and language therapist and experts by experience (people who had used a service or the carer of someone using a service).

## 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?

# Summary of findings

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 14-18th November 2016.

Prior to and during our visit we held focus groups with a range of staff who work within the service, such as nurses, medical staff, health visitors and therapists.

We visited many clinical areas and children and young people's homes and observed direct patient care and treatment. We talked with people who use services. We observed how children and young people were being cared for, and talked with carers and/or family members. We reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

During the inspection, we spoke with 55 staff members, 10 young people patients and 15 parents or carers. We also reviewed six complete sets of records. We also attended multidisciplinary meetings.

## What people who use the provider say

We spoke with 55 staff members, 10 young people patients and 15 parents or carers.

- Feedback from those who used the families, young people and children services was consistently positive. Young people told us they were listened to in a non-judgmental way and they felt respected.
- Children told us that they had felt involved with their care and staff made things clear for them during appointments.
- One parent we spoke with during a home visit said they felt much more confident and informed following visits from the health visitor and this gave them the strength to manage some difficult situations. Another parent told us they had been given support to overcome the emotion of feeling a 'bad parent' when a child was experiencing difficulties eating.

## Good practice

The web based health, text service and web chat service for young people has proven a successful way to communicate with youngsters and provide appropriate information. The planned health visitor inclusion for mothers and families will provide further support for all.

The flexibility and empathy demonstrated by the looked after children teams was unyielding during challenging times.

The Diana team provided a dynamic and holistic caring service to young people and families.

## Areas for improvement

**Action the provider COULD take to improve**

- The trust should collate infection control audits centrally to enable trust wide analysis and disseminate local results to facilitate improvement.
- The trust should review the level of school nurse provision to provide cover in line with recommendations.
- The trust should review medical and senior leadership provision within the looked after children service in line with the intercollegiate document outlining professional requirements for the looked after children provision.
- The trust should continue to highlight the additional pressure and cost associated with the arrival of the unaccompanied children in order to secure appropriate services for the increased workload.

# Summary of findings

- The trust should review the occupational therapist provision within the neuro-development sensory assessment service in order to meet increasing demand.

Leicestershire Partnership NHS 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

We rated community health services for families, young people and children as good for safe because:

- There was a good understanding of how to report an incident on the electronic system and staff understood the relevance of duty of candour. There was evidence of learning and sharing from incidents, which resulted in change of practice.
- Safeguarding was a high priority within the families, young people and children service with staff receiving safeguarding training to level three. Staff used their knowledge of safeguarding in all elements of their role and were confident to escalate concerns whenever needed.
- Staff followed infection control practices. We observed hand washing pre and post patient contact and disinfectant wipes used on all equipment, toys and floor mats following use.
- Patient records within the families, young people and children service were electronic, facilitating sharing of information with all health professionals involved in the care of a child or young person.
- Staffing levels and workloads overall met the recommended standards with the exception of services for looked after children.

**However**

- Infection control audits were not shared or collated at service level for comparison across the trust.
- Medical and designated nurse levels for the looked after children service were below recommended levels for the workload.

Good

# Are services safe?

## Incident reporting, learning and improvement

- The families, young people and children's service reported incidents through the trust electronic reporting system. Staff could describe how to report an incident and understood their responsibility to do so. However, the majority of staff said they had not reported an incident themselves.
- There were up to date incident reporting and duty of candour policies, which were available on the trust intranet.
- The families, young people and children services reported eleven serious incidents in the period October 2015 to September 2016, two of which involved the death of a child and subsequent serious case reviews.
- There were no reported never events. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- We reviewed two serious incident investigation reports and found staff had investigated these using a root cause analysis process with recommendations and actions within the conclusion. There was evidence of learning and sharing from reported incidents. Examples included implementation of a 'Hot Line' for reporting suspected child developmental delays, enabling health visitors to refer children for physiotherapy in a timely way and the use of correct terminology describing the status of pre-adoptive parents. Both incidents had resulted in child harm.
- Families, young people and children services published learning from serious incidents in a quarterly newsletter. We reviewed the July to September 2016 quarter two publication in advance of the inspection.
- The families, young people and children services' leadership meeting, which took place monthly, included quality and safety updates, incidents, complaints and serious incident learning as a standing agenda item. We looked at twelve months evidence of these meetings, attended by senior managers from all areas within the families, young people and children services.
- Staff meetings at local level included feedback and updates from the senior team. Staff we spoke with also told us they received regular communication by email and despite geographical distances across the service felt well informed.

## Duty of Candour

- Staff understood the term duty of candour and acknowledged the requirement to be open and honest when anything went wrong. The trust had an up to date duty of candour policy.
- Duty of candour is a regulatory duty and relates to openness and transparency. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred. They must provide reasonable support to the relevant person in relation to the incident and offer an apology**.** Staff were able to give an example of a breach of confidentiality, where an apology and explanation was provided.

## Safeguarding

- Safeguarding within families, young people and children services was a high priority. Staff took a proactive approach to safeguarding and focused on early identification through continual assessment and observation. Regular safeguarding reviews took place within each of the speciality areas visited, including health visiting, physiotherapy, occupational therapy, speech and language therapy, school nursing and community care.
- A recent CQC review of health services for Children Looked After and Safeguarding in Leicester City (CLAS report) had made recommendations to Leicestershire Partnership NHS Trust's families, young people and children services. This included improving multi-agency communication. Staff told us that the sharing of safeguarding concerns had improved with an electronic safeguarding system. Closer monitoring of the children's health assessments for looked after children had improved the number meeting the national time scales. Staff responsible for looked after children told us that communication had improved on the number of children in care in Leicester and those placed out of area. However, they said it was still not perfect and had examples of children known to social services for over

Good

# Are services safe?

100 days prior to referral to the trust.Staff we spoke with were not aware of some of the CLAS report recommendations. The service had developed an action plan and nominated a project lead to deliver the recommendations.

- We saw evidence of changes to practice as a result of serious case reviews, such as improving the communication with health visitors during adoption periods. We witnessed this and timely completion of health assessments discussed with staff at a team meeting.
- All staff within families, young people and children services were required to attend safeguarding children training at level three. Safeguarding training to level three is a requirement for staff working with children, young people and/or their parents and carers. Data provided by the trust showed 94% of staff within families, young people and children services had completed this training.
- Staff received regular one to one and team safeguarding supervision, which included discussion and support for safeguarding.
- Staff were expected to add to their knowledge of safeguarding through additional training sessions including female genital mutilation and child sexual exploitation. Female genital mutilation is
- Staff recorded safeguarding concerns in the child's electronic record and discussed with the line manager. The electronic system enabled the families, children and young people services team to share information with other health professionals involved in the child's care and other organisations, if appropriate such as the local NHS trust's accident and emergency department.
- Safeguarding awareness was evident in all aspects of the families, young people and children services.

## Medicines

- The trust had a medicines management policy 2015, which outlined the responsibilities of staff and the organisation for the safe and legal management of medicines.
- During the inspection, we did not witness staff dealing directly with any medication. We observed a prescription completed by a health visitor for a child with a mouth infection demonstrating safe prescribing and appropriate information given to the child's parent.
- Prescription pads were stored in locked drawers, taken out on visits and returned into safe storage at the end of the day.
- A trust audit undertaken in April 2016 of the 'cold chain' process showed 98% compliance. This refers to the management of medicines, which require storage at 2-8°C, for example immunisations. This is "maintaining the cold chain." If the cold chain was broken medicines may lose their effectiveness or become potentially dangerous.

## Environment and equipment

- The clinics we visited were appropriate for the activities taking place with age appropriate toys and equipment available.
- Staff recorded all equipment in a community maintenance schedule. However, due to the wide geographical area, equipment maintenance could be challenging. The trust's maintenance team mitigated this challenge through attendance at team meetings where staff brought devices to be checked and maintained. We saw this working for health visitors when they brought weighing scales into a meeting for maintenance and calibration.
- Audiologists calibrated their own equipment and kept records, as measurements are sensitive and can alter if knocked during transit between clinics. The central equipment log was updated regularly to reflect this.
- Staff received training in the use of equipment where necessary, such as lifting hoists.

## Quality of records

- The majority of records were electronic, the exception being some services based in the county, although patients who crossed boundaries had their records transcribed or scanned into the electronic system.
- The electronic records system was accessible to the multidisciplinary team, including general practitioners.

Good

# Are services safe?

This meant information relating to any patient contact was current. Staff told us that, since the roll out of the electronic system, data collection and quality of information had improved.

- The electronic system had a 'task facility', which enabled health professionals to direct other members of the multidisciplinary team to information of interest or concern.
- Staff on visits had toughened laptops on which they completed assessments and then downloaded onto the main system on return to their base. All computers and tough books were password protected.
- We reviewed six health visitor care plans and found them to be complete with reference to initial birth assessments and reviews at the recommended subsequent intervals of six weeks, four months, first and second year. Input was using tick boxes and free text descriptions.
- Other records viewed were the care plans produced by Diana nurses (community nurses), which were comprehensively completed to reflect the needs of the child visited. For example, for a child with a naso-gastric tube the date of tube insertion was included with all observations and care required.
- Staff completed record keeping audits every six months. We asked the trust for outcomes and actions around this but they did not provide them.

## Cleanliness, infection control and hygiene

- Clinics we visited appeared visibly clean and all equipment, children's toys and floor mats were cleaned with alcohol wipes after each use.
- Staff were 'bare below the elbow' in all clinical situations and were observed to wash their hands with soap and water before and after contact with each child.
- Single use equipment was used where applicable, for example, earpieces for audiology examinations.
- There was access to personal protective equipment, which included disposable aprons and gloves. When visiting children at home staff carried suitable supplies, which included hand sanitiser and anti-bacterial wipes.
- The trust's infection control report for March 2016 reported on hand hygiene audits. However, results were not collated at a directorate level. This meant at directorate level there was no assurance all audits had been completed as required. However, at locality level we were provided with evidence of hand hygiene audits with 97% compliance. Staff told us matrons completed these within their speciality area.
- Matrons completed a monthly audit based on 'ten point markers'. This was a list of ten infection control markers, five generic (trust wide) and five specific to the area. However, staff told us there was poor feedback on the outcomes of these audits.

## Mandatory training

- Staff and managers within the families, young people and children services directorate told us they were up to date with their mandatory training or had dates to attend. Each staff member could access their personal record of training which included attendance and renewal dates. We were shown an example of this and how to book onto updates.
- Training was a mixture of on-line and classroom learning. Staff told us they were given time and encouraged to complete all required training. Compliance was discussed at staff appraisals.
- Following the Care Quality inspection in March 2015, we asked the trust to ensure all staff completed statutory and mandatory training. Data provided by the trust prior to this inspection indicated the following compliance average across the families, young people and children services directorate. Core training 91%, governance 89%, fire 85%, basic life support 83%, mental capacity act 80%, moving and handling 87%, record keeping 89%, hand hygiene 96%, infection control 91% and safeguarding 94%. The trust target for compliance was 90%. We were assured the trust had addressed our concerns about mandatory training.

## Assessing and responding to patient risk

- Staff spoken with described how they would respond to identifying a child with deteriorating health. This ranged from arranging an appointment or visit from their GP to dialling 999.
- The electronic records included a range of risk assessments and discussions with parents or carers on appropriate actions in the event of patient deterioration. The Diana child and family support service training team

offered training to parents and carers in a range of areas, for example: tracheostomy (artificial airway) care, complex epilepsy awareness, and tracheostomy resuscitation.

- Staff completing the initial health assessment for looked after children completed an electronic risk assessment form. This included assessing any mental, emotional wellbeing, physical, or lifestyle concerns.
- For children who were unaccompanied asylum seekers, an early behavioural risk assessment was performed to identify psychological problems.

### Staffing levels and caseload

- Families, young people and children services had 872 staff in post with an establishment of 802 qualified nurses and 268 nursing assistants. There were 75 qualified nurse vacancies (9%) and 13 nursing assistant vacancies (5%), this was below the trust average of 12%. However, the distribution of vacancies varied with substantial staff shortages within school nursing of up to 40 % in some locations and health visitor vacancies ranging from zero to 30% across the city and county areas.
- Recruitment was on going and the service had recently had some success. However, leaders of the service recognised there was a national shortage of nurses who hold specialist training such as school nursing. Families, young people and children services did not meet the 2004 Department of Health paper 'Choosing Health' recommendation of one whole time equivalent (WTE) registered nurse for each secondary school and its cluster of primary schools. This was recorded on the directorate's risk register. However the service provision is commissioned based on the 'Healthy Child programme' with the specification of the local authority rather than by case load.
- Health visitor caseloads varied between the city and county, in meeting the Royal College of Nursing recommended 'normal' level of 400 maximum / 250 average. Data provided by the trust in advance of the inspection showed Leicester city area had 198 per WTE, county east 402 per WTE and county west 338 per WTE. Health visitors told us this was high as the caseloads did not take into consideration the areas of social deprivation.
- An audit in March 2015 identified 37% of child records included a named health visitor. A re-audit in September 2016 showed a 32% improvement with 69% of records with a named health visitor. Caseloads were reviewed annually using a modified acuity (dependency) tool to promote equality of workload.
- The speech and language team employed bank staff to cover maternity leave and had in place a training package to ensure competencies were appropriate for the department.
- The designated doctor for looked after children and named doctor for looked after children to support looked after children in local authority care did not meet the intercollegiate documentation guidance which recommends two paediatric consultant programmed activities (PAs, also known as sessions) per 400 children and one named doctor PA per 400, excluding clinical roles. Within the trust, there were 1300 looked after children and an additional 120 children expected under the home office plan for placement of unaccompanied minors. This equates to a requirement of 9.75 PAs. The trust's provision was one PA at the time of our inspection.
- A designated nurse within the looked after children service was performing both strategic and operational roles. This does not meet the intercollegiate documentation guidance, which outlines the roles and responsibilities of those involved in looked after children services. The designated nurse had a strategic management responsibility and named professionals had responsibilities, which included working directly with looked after children. This meant the designated nurse was combining both roles with an increasing, high pressured workload which may be unsustainable.
- The Diana children's community service consisted of a variety of services to provide support for children and young people with complex, life threatening and life limiting health conditions and to support the health needs of children in the community environment. The staffing level and caseloads varied according to child dependency within each service and was generally considered manageable. However, within continuing care, there were five children awaiting allocation or to be approved for the service through a panel of assessors.

Good

# Are services safe?

## Managing anticipated risks

- There was an anticipated risk associated with a rising workload in relation to the expected arrival of unaccompanied asylum seekers. The designated nurse with input from the designated doctor completed a business case for staff to cover the increasing workload.
- The trust had a lone working policy, staff updated diaries to reflect their location, and staff attended home visits in pairs when a safety risk was identified.

Good

# 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

We rated community health services for families, young people and children as good for effective because:

- Care and treatment was planned and delivered in line with current evidence based guidelines, standards, best practice and legislation.
- Staff were trained within their speciality and new staff supported.

**However**

- The looked after children service did not meet the standard of quality audit for looked after children health assessments.
- Some policies and guidelines were out of their review date.

## Evidence based care and treatment

- Staff planned and delivered treatment and care within the families, young people and children services in line with current evidence based guidelines, standards, best practice and legislation.
- The standard operating guidance for health visiting teams delivering the healthy child programme (revised 2015) was based on the healthy child programme, Department of Health (DOH) 2009.
- The trust achieved UNICEF Baby Friendly Initiative Accreditation in January 2016. Information and guidance was given in line with UNICEF guidance. The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding and to practise in accordance with the International Code of Marketing of Breastmilk Substitutes
- The health visitor programme of visits and electronic records reflected the targets within the standard operating guidance. For example, newborn visits were arranged, where possible, at a time when both parents were available. We accompanied a newborn visit and found information given was evidence based and included a wide range of topics including advice on safety and vaccinations.
- The speech and language team were trialling a new technique called BEST (building early sentences). This was for three to six year old children who did not join more than two words together, developed by a UK university. The speech and language therapist told us early indications of pre and post assessment were beginning to show excellent results although these were not yet published.
- Dieticians utilised National Institute for Health and Care Excellence (NICE) guidelines and guidance from recognised charities when discussing dietary needs with parents selecting formula milk for their babies. Updated information based on the most recent research was discussed.
- Specialist occupational therapist assessment for neurodevelopment followed the NICE guidance for autism spectrum disorder diagnosis.
- Some local policies and guidelines were out of date. This was raised with a service lead who confirmed they were aware of this and had a planned programme of policy review dates for which we were shown documentation.

## Nutrition and hydration

- Health visitors held breast-feeding cafés weekly in social centres to enable mums to share experiences and receive advice.
- School nurses provided drop-in sessions where young people could discuss nutritional needs or concerns about their weight.
- Dieticians ran weight management clinics working closely with families to provide support and guidance to manage the weight of the children seen.

## Technology and telemedicine

Good

# Are services effective?

- Staff used tough books to electronically input assessment information. This was then downloaded onto the central server on return to the office. All information technology equipment was password protected.
- Health visitors could refer directly to community paediatricians with concerns regarding developmental behaviour.
- We saw how technology (tablets) was used to interact and involve children in researching and understanding their medical conditions or to identify specific health needs.
- School nurse service had implemented a confidential text service for children to contact a school nurse in relation to any concern they had. Additionally, there was a web chat facility for young people held each Monday where they were able to ask questions and share experiences.
- The trust worked with a local council to provide Health for Kids and websites aimed to help children and young people to stay healthy and look after their health.

### Patient outcomes

- The families, young people and children services had recently undergone an independent review of data collection and were in the process of developing systems and processes to improve the quality and depth of data collected.
- Information provided by the trust showed immunisation rates across the four areas; Leicester city, Leicester west, Leicester east and Rutland were within target (95%) for children aged one to two years and below target (92 to 94%) for children aged two to five. This reflects the national average as reported by Health and Social Care Information - NHS Immunisation Statistics: England 2015.
- Booster immunisations for children 13 to 18 years of age were below target at 77 to 87%.
- An audit of families receiving face-to-face contact with a health visitor on local neonatal units within 10-14 days identified 55% compliance. This did not meet the trust's healthy child programme universal offer of 100%. The audit report had a clear set of actions to raise awareness of the neonatal unit pathway and training for newly qualified health visitors and was to be re-audited in November 2016. A senior health visitor told us visits to the unit had increased and they were confident the audit would show improvements.

### Competent staff

- Staff working within families, young people and children services were suitably trained to carry out their specific roles. For example, nurses working with looked after children met the standards and base line competencies outlined in the Intercollegiate Role Framework 2015. The looked after children service included care of unaccompanied children seeking asylum.
- An occupational therapist had received support to become a specialist sensory assessor for children with suspected attention deficit disorder.
- All staff we spoke with told us they had been appraised within the last 12 months, or had dates to attend. Data provided by the trust supported this with 92 to 100% of staff having recorded appraisals. Staff told us agreed objectives where meaningful and achievable.
- A trust clinical supervision policy dated 2016 was available on the intranet. Clinical supervision is a formal process of professional support and learning that enables individual practitioners to develop knowledge and competence, be responsible for their own practice and enable patient protection and safety of care in a wide range of situations. Staff told us they had one to one meetings with their supervisors and regular team meetings included sharing and learning specific to their specialities. However data provide by the trust showed a varied rate of health centre based clinical supervision from 100% in some centres to as low as 25% in another. However, some of the teams consisted of three members of staff, which would account for the high percentage.
- The speech and language team employed bank staff to cover maternity leave and had a training package to ensure competencies were appropriate for the department.
- Staff in the Diana child and family support service had a wide range of skills appropriate to their areas of expertise. Examples included child and family support, respiratory physiotherapy, continuing care, acute and ongoing nursing care, transitions support and a cultural

link post. The Diana team included a training team, which provided continual education for health, and non-health related care staff to support the safe provision of care for children in their own homes. The training team provided training for parents, carers and anyone who was involved in caring for a child at home, school or a residential facility.

### Multi-disciplinary working and coordinated care pathways

- The multi-disciplinary single point access system ensured referrals to the families, young people and children services were handled effectively with instant referral to other agencies such as therapists. This had not been audited at the time of our inspection.
- We saw evidence of joint working across the families, young people and children services. This included, for example, joint development clinics involving a paediatrician and paediatric physiotherapist, where examination of a child resulted in both medical and physiotherapy advice being provided to the child's carer. This supported effective care planning and delivery and reduced the number of clinic visits for the child.
- The neuro-development pathway occupational therapist, worked closely with paediatricians and within the autism spectrum disorder pathway to ensure children received a multidisciplinary approach to their diagnosis.
- Staff from schools, children's centres, therapists and health attended care navigation meetings to plan a joined up approach to caring for children and families.
- Therapists were able to refer to other specialists for further investigation, for example, an audiologist could directly refer into the local ear nose and throat department for their opinion or advice.
- We attended a children in care council meeting, which was chaired by an elected member of the group and attended by specialists, nurses, social workers and children's rights specialists. This group discussed items of specific relevance to them including transition, access to support services as well as social event planning.
- Community paediatricians described having open access to the Child and Mental Health Services (CAMHS) team. We did not see evidence of combined health and mental health clinics.

### Referral, transfer, discharge and transition

- There was evidence of cross health care working with internal specialist referrals. We observed an audiologist getting consent from a parent to refer a child to a local NHS trust ear nose and throat department. A full explanation was given and information provided about possible treatment options and waiting times. Referral pathways were in place for many specialist services.
- The trust had a transition planning protocol for young people providing clear guidelines on processes and standards for all clinicians working with young people aged between 14 years and 25 years.
- Discharge information was shared with GPs either electronically or via paper summaries according to the electronic system used by the GP.
- The transition lead supported staff within FYCP when considering the preparation for adulthood agenda. There was a small team commissioned within Leicester City. However, there was no similar support within the other local Clinical Commissioning Groups (CCG's). The team aimed to support young people and families with ongoing healthcare and think about the future care and support needed as they transition into adulthood. Initial contact was at school year nine (age 14 years) in line with the Children's Act 2014. This Act placed a duty on local authorities to conduct transition assessments for children, children's carers and young carers where there was a likely need for care and support after the child turned 18. Assessments were based on life's four needs – employment, independence, health and relationships. Assessment forms were available on the electronic records system. Subsequent assessments were yearly up to 17 years when links were made with adult social care if required. The service had good links with adult social care. However, there was no clinical commissioning group funding for transition services, which meant no further staff could be employed to support this at present. At the time of our visit, there were 170 young people up to the age of 19 undergoing transition with 19 dependant young people up to the age of 25.
- All young people who transferred to adult services had a written plan that they helped to create.

### Access to information

Good

# Are services effective?

- The electronic record system was accessible by all staff, which meant there was information sharing between health professionals.
- Parents and carers were given information and signposted to information sources relevant to any queries they may have. One parent was advised to watch a U-Tube film explaining the difference between gagging and choking.
- Each service within families, young people and children services had information leaflets explaining the service they provided and giving directions to access further information. The leaflets also had useful contact numbers, for example support groups or societies.
- Families, young people and children teams could print information in non-English languages if required although these were not readily available in patient waiting areas.
- Areas not using the same electronic notes could be granted read only access to enable information sharing and continuity of care, for example with mental health teams.
- The school nursing service had a text service called 'Chat Health' and a web-based forum, providing young people with an opportunity to ask health or social related questions through a familiar medium. A response to texts was provided within one working day. Additionally young people were given a booklet called 'Your Digital Health'- everything you need to know about how to get health advice in and out of school. This covered a range of areas including, sleep, exam stress, self-harm, mental health, sexual health, anxiety and other health or social related topics.

### Consent

- The trust consent policy included guidelines relating to consent for children. Consent to care and treatment was obtained in line with legislation and guidance, including the Children's Acts 1989 and 2004.
- We saw staff give parents or carers a full explanation and sought verbal consent prior to any contact with babies and young children in clinics. Staff documented consent in the child's electronic records.
- Staff gave children an explanation and asked if it was okay to undertake an examination, in suitable language, prior to any physical contact.
- School nurses demonstrated an understanding of judging children to be competent when giving contraceptive advice or providing pregnancy tests using the Fraser guidelines. Fraser guidelines is a specific assessment of competency when providing contraceptive advice or providing pregnancy tests. Where appropriate young people between 16 and 18 were encouraged to involve family or carers in tests and treatment.

Outstanding ☆

# Are services caring?

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

## Summary

We rated community health services for families, young people and children as outstanding for caring because:

- Feedback from those who used the families, children and young people services was consistently positive. Young people told us they were listened to in a non-judgmental way and they felt respected.
- We observed positive interactions between staff and children of all ages with use of age appropriate language.
- There was an outstanding approach to family and patient care utilising or creating tools to assist children to understand their condition or prepare for treatment. Whole families were included where appropriate.
- Relationships were built with hard to reach families. All contacts were child and family centred.
- School nurses had been involved in the design and development of technology to aid contact and communication with young people.
- Families and children were actively involved in care planning.

## Compassionate care

- Children and young people told us they felt respected and listened to in a non-judgmental way. During the inspection, we observed several instances of positive interactions, which were both age and language appropriate.
- Child and family support workers used a holistic, whole family approach when caring for children with specific needs. They created tailor made play equipment and resources to assist children to understand the treatment they were receiving which could be anything from having an injection to more intimate procedures such as an enema. The service also provided play therapy and emotional support for children and their families when facing end of life.
- The paediatric phlebotomy (blood taking) team used stickers to reward young children for 'being brave' whilst having a blood test.
- Nursery nurses visiting children at home involved the whole family, including siblings, in assisting and planning care and play for children at home.
- Staff were clearly passionate about their role and this was evident when accompanying nurses visiting a family at in their home who spoke positively about how the service had helped them through some difficult situations. One nurse said she felt she was 'sitting on a pot of gold' working and supporting families.
- Staff demonstrated awareness that the environment did not always support confidentiality. They encouraged children and young people to wait until they were in a private room to discuss concerns and ask questions.
- Staff spoke about treating all families as equals.

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

- Staff were proud of how they built positive relationships with families and maintained contact with those who were difficult to reach. The team was able to provide evidence of work with a large family, ensuring there was consistent advice and support offered to them. This was through record keeping and communication with other health professionals. This met one of the trusts priorities for 2015/16 to improve the trust's approach to family-focused care and strengthen relationships between staff groups working with different members of the same family.
- We observed close working with a mother and child explaining about hearing loss using simple language and pictorial information as reinforcement.
- Young people were encouraged to take responsibility for self-medicating, where appropriate. We observed a nurse working with a young person and a parent to put in place strategies to assist this through routines and praise for compliance. The parent received advice about dealing with challenging behaviours.
- Children told us that they had felt involved with their care and staff made things clear for them during appointments.

Outstanding ☆

# Are services caring?

- A child centred approach to care was apparent with all staff. We observed looked after children nurses planning and implementing care of teenagers carefully and thoughtfully. This included using opportunities to address concerns such as internet safety and dealing with eating disorders. The strong working relationship with foster carers was valued by all involved.
- We saw senior therapy staff driven and enthusiastic about finding opportunities for a child with severe disabilities to gain movement and be able to communicate.

### Emotional support

- There was a cultural link worker who was able to offer specific culturally centred support to service users or advise staff on cultural diversities.
- One parent we spoke with during a home visit said they felt much more confident and informed following visits from the health visitor and this gave them the strength to manage some difficult situations. Another parent told us they had been given support to overcome the emotion of feeling a 'bad parent' when a child was experiencing difficulties eating.
- Clinics and home visits were consistently managed in a way which allowed non-judgmental conversation between the health professional and carer or child.

Good

# Are services responsive to people's needs?

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

## Summary

We rated community health services for families, young people and children as good for responsive because:

- The needs of families, young people and children were taken into account when planning and delivering services.
- School nurses provided a text advice service called 'Chat Health' and a Web based forum to enable young people to access advice through a system they were familiar with. We saw two examples of this confidential service in action.
- Care navigators provided help to families negotiating the complexity of the various care services available.

However we found:-

- There was a lack of reporting and monitoring of informal complaints, meaning the service was unable to monitor and recognise themes of concern with the children's service.
- Appointment letters did not include additional information about the service the patient was to see; this meant some parents were not clear about the purpose of an appointment.

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

- The children in care council meeting gave children a chance to be involved in the services provided for them. They completed surveys and spoke with
- There was a home office plan for placing unaccompanied children into the Leicester, Leicestershire and Rutland area. The expected number was 120 with 50 being placed within the city and 70 within the county. This equated to an increase of 10% to the existing 1300 within Leicester, Leicestershire and Rutland area. The trust did not have a strategy for the increased financial demand.
- The looked after children service staff and the CQC Review of health services for Children Looked After and Safeguarding in Leicester City (CLAS) report expressed concernsaround the increasing numbers of children in need, unaccompanied children and child protection cases without additional resource. The looked after children team had raised awareness of unaccompanied asylum-seeking children and young people by submitting a business plan for increased funding to enable them to meet the needs of vulnerable children and young people.
- An audit had identified health visitor new birth reviews within 10-14 days were not occurring for babies admitted to neonatal units. As a result, the service had planned and launched a neonatal pathway to ensure first health visitor contact took place for these new-borns whilst on the units. The trust was monitoring feedback from staff and patients. The trust planned to present their findings to the families, young people and children services' patient safety and experience group. We saw evidence of training on capturing these visits on the electronic notes system.
- Families, young people and children's service operated a neighbourhood model, dividing services into fourteen neighbourhoods across the Leicester, Leicestershire and Rutland area. Neighbourhood leads had a key role working alongside other managers and clinicians in planning and delivering care within their neighbourhood. They worked together with other leads to establish links across families, young people and children services and with other agencies, promoting cross-organisational working. Neighbourhood leads built local profiles, which identified services, practitioners, assets, opportunities and needs within their local population.
- The families, young people and children services had care navigators who supported the co-ordinated planning and delivery of services for 0 to 19 year olds within the neighbourhoods.
- A physiotherapy call line meant that professionals could call and ask advice or make appropriate referrals with parents and children present to answer questions.
- Specialist looked after children nurses and health visitors performed looked after children health assessments to ensure the child was seen in age appropriate environments.

Good

# Are services responsive to people's needs?

## Equality and diversity

- The Diana children's community service included a cultural link support, which provided advice to staff and supported families within the Leicester, Leicestershire and Rutland area, which served a culturally diverse community.
- The trust had an in date interpreting and translation policy. Interpreters were available through a local agency and telephone line. Staff told us interpreters were available if they were able to pre-book. However, there were difficulties owing to the wide range of languages and their associated dialects within the Leicester, Leicestershire and Rutland area.
- Appointment letters and information was sent to parents and carers written in English, although advice was provided about receiving information in other languages on request.

## Meeting the needs of people in vulnerable circumstances

- The families, young people and children services had a designated nurse for looked after children who was responsible for both Leicester city and county areas, including Rutland. Health assessments for this vulnerable group were generally carried out in health centres or schools. However, staff arranged home visits if appropriate, for example, older looked after children could be seen at home after school, to avoid being taken out of class during the school day.
- The families, young people and children services employed care navigators who helped families and carers negotiate their way through the complexities of services available to them.
- One parent told us, appointment letters received did not include additional information about the service they were to attend. This meant some parents might not be clear about the purpose of an appointment.

## Access to the right care at the right time

- The families, young people and children services service for Leicester, Leicestershire and Rutland provided data which demonstrated referral to treatment times for occupational therapy, physiotherapy, speech and language, audiology and medical services were better than national target of 126 days, with waiting times of between 24 and 76 days. NHS England describes referral to treatment time as: a waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to a consultant led service.
- Health visiting services monitored compliance with national targets for visits and child development checks. Between July 2016 and September 2016 93% of babies received a face-to-face newborn visit within 14 days. This was slightly below the national average of 97%. The number of children receiving a 12 month check was 88%. This was similar to the national average of 91%.
- Looked after children initial health assessments varied, this was in part due to delays in communication with the looked after children team regarding children entitled to this service. The key performance indicator for initial health assessments was 28 days and once referred to the team they were able to meet this target 93% of the time. However, due to delays in referral by local authorities some children were not assessed for up to 170 days from being placed into care, this reduced the overall compliance to 44%. We looked at a spreadsheet of all referrals received in September 2016 which showed 19 of 37 referrals were delayed. Senior staff had raised this with social services. The looked after children team receive 29 to 45 requests for initial health assessments each month.
- The looked after children service had a care administrator responsible for monitoring referrals and co-ordinating their initial health assessments and subsequent six monthly assessments for those under five years of age and yearly for those over five years.
- The Diana child and family support service was able to see all referrals meeting their acceptance criteria, within five days.
- There was a wait of up to nine months for children requiring neuro-development sensory assessments to support a diagnosis of attention deficit disorder. However, the service had recently increased the therapist hours to equal one full time equivalent (37 hours). Staff told us that an additional full time therapist would be needed in order to meet referral to treatment times.
- Staff told us the single point access referral system had improved access to families, young people and children

services. Children could be referred on to multiple services from a single referral. All referrals were monitored by relevant clinicians to monitor waiting times and subsequent referrals. The trust anticipated catching up with the delayed referrals by January 2017.

### Learning from complaints and concerns

- Data provided by the trust for the period January to August 2016 showed 28 formal complaints. Of these 71% (20) were upheld locally and one was referred to the health service ombudsman, which was not upheld.
- Staff told us they were unaware of any complaints and believed there to be very few. However, if they received a complaint they would refer the person to the patients' advice and liaison service. This meant informal complaints and concerns were not always captured or reported and the service was unable to monitor and recognise themes of concern with the children's service. It also meant staff were not aware of any actions required for improvement.
- Information relating to the patient advice and liaison service was available within all the health centres visited; leaflets were included in information packs given to patients: for example at antenatal health visitor clinics and information could be found on the trust's web site.
- Complaints and incidents featured as standing agenda items for staff meetings.

Good

# 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

We rated community health services for families, young people and children as good for well-led because:

- There was a five-year plan and strategy for the families, young people and children service.
- Staff were actively involved in service planning through a listening into action programme.
- Staff consistently told us they were proud of working for the families, young people and children service.
- There had been increased stability within the management team with staff saying senior management had become increasingly visible.

However

- Staff expressed concern about the future for some services within which were under tender for commissioning purposes.

## Service vision and strategy

- The families, young people and children's service had a five-year plan 2016 to 2021, which aimed to improve the health and well-being of families, young people and children in Leicester, Leicestershire & Rutland. The plan included service improvements and cross-organisational working with the NHS, voluntary sector, community groups and the involvement of family and friends.
- The plan included a strategic direction, which reflected key documents such as the Marmot review – a Kings Fund review on inequalities in life expectancy, future in mind – promoting, protecting and improving children and young people's mental health and the Children's Act 2014.
- The families, young people and children service was working closely with other providers locally to provide care in the community.
- The families, young people and children service senior team felt the neighbourhood approach had strengthened their bid for recently tendered local authority contracts for health visiting and school nursing alongside their implementation of agile working, which enabled staff to work flexibly to suit personal and service need.
- Staff generally understood the vision and strategy of their service and were positive about working together to improve services.
- Staff we spoke with during our inspection and at focus groups, prior to the inspection told us they were concerned about their future in relation to the tendering process for services. However, they also said they were regularly informed about what was happening in staff meetings and were aware of a sharing event planned for December 2016.

## Governance, risk management and quality measurement

- The risk register report for families, young people and children services included details of identified risk, controls for managing the risk and actions to reduce risk. Items were red, amber, green (RAG) rated according to severity. Risks with a residual rating of red (high risk) were information technology infrastructure and contractual risk for families, young people and children services. All other risks were rated as moderate or low risk. Each risk had identified named responsibilities actions and review dates.
- Governance within the service had a clear structure with systems and processes for escalation. Monthly families, young people and children services leadership meetings included identified top risks as a standing agenda item. We looked at meeting minutes which had named actions for items discussed and feedback (matters arising) and progress on previous actions. Also included in the minutes were discussions related to reported incidents.
- Each speciality within families, young people and children services held regular team meetings, which included risks and safeguarding as regular agenda items.

Good

# Are services well-led?

## Leadership of this service

- Managers of the services provided within families, young people and children services were suitably qualified and experienced to do their job. Over the past four years, there had been changes in senior management. However, staff told us there had been stability recently and this had had a positive effect. Frequent board walks (visits to departments by senior managers) to meet staff and observe their daily work had been well received by all departments. Staff told us these visits had increased and included more areas since the last inspection in March 2015.
- Leaders were approachable with an open door policy. Staff felt they could talk to their managers confidentially and were able to raise concerns or make suggestions without fear.
- The looked after children team said local leadership had helped raise the profile of looked after children and had responded positively to the previous Care Quality Commission inspection report.
- Managers spoke very positively about their teams and were proud of their commitment, especially during times of high demand on the service. They told us there was good team working with staff willing to help each other.
- Managers recognised some of the difficult and stressful daily work undertaken by their staff. We observed a manager taking time to listen when a nurse was clearly distressed following a conversation with a young person.

## Culture within this service

- The trust had a lone worker policy. Staff notified a colleague (buddy) at the end of the working day. The clinical areas we visited had alarms for lone workers to alert centre staff if help was required. We saw evidence of lone worker risk assessments taking place to protect the safety of staff working in isolated locations.
- There appeared to be effective relationships between staff working within families, young people and children services and mutual appreciation of the demands of the job.
- All staff we spoke with were proud of the service they offered to families and children, and managers told us they were proud of the people working for them. Staff also described a patient centred culture, which targeted improving child health outcomes. We heard staff discussing the most appropriate way to support parents with six-month-old babies, including support groups.
- Staff have been offered psychological (stress management) and emotional support through a counselling and psychological support service for NHS staff.

## Public engagement

- Information provided by the trust showed the family and friends test to be positive for whether service users would recommend the service scoring 90 to 100%.
- Young people were involved and consulted around the development of the web chat facility and the transition planning for young people from children's to adult services..
- The trust was looking for family involvement in a 'Surviving Crying' study by the trust. One of the aims of the study was to improve the support for families locally.

## Staff engagement

- The trust had maintained engagement with staff through 'Listening in Action' (LiA) forums to enable staff to participate in discussions. Staff who had attended LiA sessions described them as good for problem solving. They told us sessions were published on the intranet and they could book to attend. Several staff told us they intended to go and take ideas for improving their service.
- Staff survey results 2015 showed a positive outcome for professional development opportunities with 89% of respondents saying the organisation provided equal opportunities for career progression or promotion. However, staff saying they had suffered work related stress was 37%. These scores generally reflected those of other similar trusts nationwide.

## Innovation, improvement and sustainability

- The neighbourhood model developed through a transformation programme during the period 2013 to 2015 had created 14 Neighbourhood areas aligned to local authority boundaries. The neighbourhood model was designed to strengthen connections with local

authority services. Practitioners operating within each geographical area had established relationships and common working practices to support the local population.

- School nurses told us of positive leadership and being included in strategic development. The clinical lead had introduced a development group, which staff described as a 'bottom up' approach to service improvement.
- Introduction of BEST (building early sentences therapy) had shown a marked improvement in early sentence development over an eight-week pilot. This was an initiative supported by a UK university.
- The Diana child and family support service was developing feedback forms, which were user friendly for their service users. For older children and carers there was a support rating scale which asked six questions about the service they had received with a rating of zero (poor) to five (Good). They had also prepared a pictorial version, using smiley to sad faces for younger service users. Additionally large print versions were available for the visually impaired. This was to be trialled in forthcoming weeks.
- The looked after children service had found the friends and family test was not applicable to their service users and were working with a local university on a research project to address this issue. They were waiting for ethical approval to commence the project, which they hoped, if successful, would be adopted nationally.