Gloucestershire Care Services NHS Trust

R1J

Community health services for children, young people and families

Quality Report

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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)
R1J01	Edward Jenner Court		

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

Overall community health services for children and young people were found to be good. We found that services were safe, effective, caring, responsive and well-led.

Gloucestershire Care Services NHS Trust provided specialist community services for children, young people and families in Gloucestershire. As part of this inspection we talked to 28 professionals delivering the service. We also met and spoke with five children and young people and nine parents. We visited services at Quedgeley Clinic, Stroud General Hospital, the Springbank Resource Centre and the Independent Living Centre in Cheltenham, the Dilke and Lydney hospitals and trust headquarters. We also spent time on school and home visits with the school nurses, community children's team, health visitors and therapy staff.

We judged the safety of community health services for children and young people as good. Risk was managed and incidents were reported and acted upon with feedback and learning provided to most staff. This was with the exception of the way medicines were administered by health care assistants in the complex care team.

Care was effective, Care was evidence based and followed recognised guidance. There was excellent multidisciplinary team working within the trust and with other agencies.

Care and treatment of children and support for their families was delivered in a compassionate, responsive and caring manner. Parents spoke highly of the approach and commitment of the staff who provided a service to their families.

We saw that staff understood the different needs of the children and young people and designed and delivered services which met the specialist needs of children.

There were clear lines of local management in place and structures for managing governance and measuring quality.

Summary of findings

Background to the service

Information about the service

The trust provided specialist community health services for children, young people and families which included specialist nursing services, health visiting services and therapy services. The services supported children with long-term conditions, disabilities, multiple or complex needs and children and families in vulnerable circumstances. The service worked with infants, children and young people aged 0 to19 years, their parents and carers and a range of other agencies in Gloucestershire. Children and young people represented 22.8% of the population of Gloucestershire.

Services were delivered at localities across the region with staff covering particular geographical areas. During the inspection we visited Quedgeley Clinic, Stroud General Hospital, the Springbank Resource Centre and the Independent Living Centre in Cheltenham, the Dilke and Lydney hospitals and trust headquarters. We spent time with the children's complex care team who provided a home based respite care to children with complex health needs who required nursing interventions. We also spent time on school and home visits with the school nurses, community children's team, health visitors and the immunization team.

We observed a multi-professional postural management assessment clinic, therapy clinics and a meeting where housing adaptations were discussed. We also spoke with children and young people who used the services and their parents or carers. We observed how children and young people were being cared for and looked at care and treatment records.

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team of 34 included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community children's nurse, a palliative care nurse, a sexual health consultant and specialist sexual health nurse, a health visitor, a child safeguarding lead, a school nurse, directors of nursing, an ex-chief executive, a governance lead, registered nurses, community nurses and an expert by experience who had used services.

Why we carried out this inspection

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

How we carried out this inspection

During our inspection we reviewed services provided by Gloucestershire Care Services NHS Trust.

To get to the heart of people who use services and their 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 core service and asked other organisations to share what they knew. During the visit we held focus groups with a range of staff who worked within the service, We talked with children, young people and their parents / carers who use services. We observed how they were being cared for and reviewed care or treatment records.

What people who use the provider say

We spoke with children, young people and parents who used the service and they were consistently complimentary about the care and professionalism of the staff that provided the services. We were told that staff were respectful, caring and compassionate and were positive and supportive when dealing with stressful situations, such as children's illnesses. One parent told us "It's a fantastic service I've had some great tips and advice and it's made a marked difference to how I approach some things" and another felt reassured as staff were "Always there to speak to me during sessions and on the telephone for support in between appointments."

Good practice

The seven day service provided by the children's community team

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

Medicines were being administered to children in the complex care team that had been drawn up by parents, but were not labelled. Staff were administering this medicine but were not able to confirm the medicine or dose that they were given. No policy and protocol was in place to identify this as a risk or to support staff in administering medicines.

The health visitor team had health visitors who were able to prescribe medicines using external prescriptions. No processes were in place to prevent the possible misuse of these prescriptions or to audit their use amongst the team.

Action the provider SHOULD take to improve

Gloucestershire Care Services 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

Overall we judged the safety of community health services for children and young people as good

Staff knew how to report incidents using the on-line reporting system and were encouraged to report incidents. Most staff received feedback following incidents and learning was shared with them.

Staff adhered to infection prevention and control procedures and staff had completed the appropriate training. Equipment was correctly serviced and maintained.

The majority of staff were up to date with mandatory training and staff were receiving clinical supervision and annual appraisals.

Staff we spoke with were knowledgeable about the trust safeguarding process. They were clear about recognising possible signs of abuse or neglect of children and young people and their responsibilities.

We observed very good recording kept throughout the children and young people's services. Each professional had access to the electronic care records leading to improved co-ordination of each child's care.

A risk was identified regarding the administration of medicines within the complex care team. We did not see this risk replicated across any other services within children's and young people's services or the wider trust.

Incident reporting, learning and improvement

- The trust used an electronic risk management system for incident reporting. Staff had access to this via their laptops as part of their mobile working. However, staff told us that it depended on the connection at the time and often they would wait until they were back in their base office before completing the incident form. We did not see any evidence that this made staff less likely to report incidents.

Good

Are services safe?

- Staff were open, transparent and honest about incidents. All staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them. Some staff told us they received feedback from any incidents that they reported however other staff told us receiving feedback was not always consistent. Some staff told us that they always received feedback from incidents they reported, whereas other staff told us that there were times when they had not received any feedback. We saw evidence that incidents were discussed amongst the staff through the regular staff meetings across all professional groups within children and young people's services. With one particular incident, we saw that staff were still talking about it months later, using reflective practice on their own work to make sure they were not making similar mistakes. This showed us incidents were discussed appropriately to ensure staff and the trust learnt from its mistakes.
- Once reported via the electronic incident reporting system, incidents were then reviewed by the managers for that particular service and where necessary an investigation commenced. We saw evidence that these investigations took place appropriately and any learning that resulted was acted upon. Incidents are discussed through the clinical governance meetings both at a local level and trust wide.
- We observed that people who used the service were told when something had gone wrong that affected them and where appropriate were kept informed of the actions taken.

Safeguarding

- There were systems in place to keep children and young people safe and safeguarded from abuse. Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of child abuse and what actions they would take should they have safeguarding concerns about a child or young person. Staff were trained to recognise and respond in order to safeguard children and young people. Records indicated that safeguarding training to at least level 3 was up to date for the majority of staff. Where staff were not up to date, plans were in place for them to complete their safeguarding training as quickly as possible.
- Staff were aware of the different forms of abuse including child sexual exploitation (CSE) and gave us examples of what they would do if they had concerns. We saw evidence that school nurses discussed CSE at their staff meetings and how to engage the school children in their education sessions on CSE.
- Staff were aware of the county and locality specialist nurses for safeguarding leads for the trust who supported a programme for safeguarding supervision and peer review. All staff were aware of and able to access supervision and reviews and were able to show us the supervision policy.
- Referral pathways were in place across the different specialist areas. These reflected the safeguarding procedures in the Trust and the local children's safeguarding board.
- Safeguarding was reported quarterly directly to the trust board. The report showed that the board were kept informed of serious case reviews and the learning that resulted from them.

Medicines

- We were informed that in the complex care team, the unqualified staff caring for the children overnight administered medicines that had been pre-drawn up in syringes by the children's parents. They were not labelled and had not been drawn up in the presence of staff. The medicines were administered either orally or via a PEG tube. This presented a risk as staff were administering medicines but were not aware what actual medicines they were. When we asked if this was in accordance with the medicines management policy we were told that no medicines policy was in place within the complex care team. We noted that this particular issue was also not recorded on the risk register for children and young people's services. We raised this with the manager who told us that the medicines should be labelled. However, staff told us that they never were. The NMC medicines management policy states in standard 14 (preparing medication in advance) "Registrants must not prepare substances for injection in advance of their immediate use or administer medication drawn into a syringe or container

by another practitioner when not in their presence." We did not identify these concerns in any other area within children child's and young people's services, or the trust as a whole.

- Some health visitors within the health visiting teams were able to prescribe medicines from a predetermined and approved list. Each health visitor prescriber was able to order a prescription pad. We asked to see the audit arrangements for these pads. We were told that the pharmacy completed the prescription audits for the service; however, there were no arrangements locally to do so. This meant that there was no system in place to effectively monitor the usage of these prescriptions or to prevent their misuse.
- We looked to see how medicines were recorded and stored for the immunisation team. We were told that all the immunisations were ordered and stored via a contract with the local acute hospital. The immunisation team requested the immunisations they needed for a school clinic and these were then delivered to the trust in a timely way. We saw that the medicines were stored in fridges within a secure room with limited staff access. The fridge temperatures were checked daily to make sure the medicines were stored at the correct temperature. Special precautions were taken when transporting the medicines to school and these included the use of cool bags and the constant monitoring of temperatures.
- Where medicines were administered, we saw that they were recorded appropriately, including batch numbers for immunisations. Patient group directions were also in place and we saw evidence that these were followed by staff.

Environment and equipment

- Access to therapy clinics was secure and maintained the safety of children and young people using the service. Areas were clean, tidy and well ventilated, and most clinics were suitable for children and young people. In all the locations we visited, we saw that a range of toys and activities were available for children.
- Staff told us they had access to the equipment they needed for the care and treatment of children and young people. Staff also told us that they were trained in its use where necessary. The equipment staff used was well maintained in line with manufacturer's instructions.
- Staff had access to laptops to support mobile working. This meant they were able to access the patient records, emails and policies when away from their home base. Some staff told us they updated records whilst in their car and were concerned about the long-term implications of working in this position. We asked staff why they did this, and were told it was only where they knew they could get a good mobile signal in certain parts of the county.
- We observed that staff followed trust policies with regards to disposal of clinical waste disposal. As an example, the immunisation team took the necessary equipment with them to schools to dispose of sharps. These containers were then sealed and returned to the trust for disposal.

Quality of records

- Children and young people's services had in place an electronic records system which meant staff could access the system via mobile working. When staff attend a school or clinic staff had access to the individual child's records via their laptop. Staff were able to update records in real time and had access to multi professional notes to see what another professional had written.
- We reviewed nine sets of records and found them all to be clear and contemporaneous. Where appropriate, detailed care plans were in place and were reviewed and updated regularly in conjunction with the child's family. This made sure they were tailored to meet the needs of each child. All consultations with the child were documented. We were told that where connectivity issues arose such as loss of mobile signal, hand written notes were made and the system updated at the earliest opportunity. We saw evidence that this took place in a timely way. The electronic system was available off-line and would download any information once access was restored. This meant there was a backup system in place in the event of a power or network failure.
- Each service within children's and young people's services undertook their own record keeping audit. The majority of these took place before the introduction of the electronic record keeping / patient administration system. As an example, in the 2014 audit of record keeping, out of the 17 audit questions, the children's community team failed to meet trust targets in all 17

questions, 15 of which were rated as red. The scoring system used a RAG rating (red, amber, and green). We were told that this was possibly due to the introduction of the electronic record system and the initial problems staff had with connectivity at that time. An action plan had been produced as a result of the audit. This was comprehensive with dates for action and specific staff that would action each point. We saw evidence that progress had been made with action plans. A re-audit was planned once the new electronic system had been embedded.

- The complex care team undertook a record keeping audit in 2014. Out of 47 criteria, they were compliant with 35 of the criteria; however four of the criteria were rated as red. An action plan was in place. This plan was monitored through the clinical governance meetings for children's community nursing.

Cleanliness, infection control and hygiene

- During our inspection we observed staff wash their hands regularly and use hand sanitiser appropriately and were bare below the elbow in accordance with trust policy Personal protective equipment was available such as aprons and gloves. This was available for staff in clinics, schools and at home visits. All the clinics we visited during our inspection were well maintained and clean.
- We observed staff cleaning equipment and environments where necessary. As an example the immunisation team made sure the tables were cleared in the school prior to starting their clinics.

Mandatory training

- Staff training matrices were available in locality therapy teams and monitored by therapy leads to review attendance and expiry dates, thereby ensuring compliance with mandatory training. All staff told us they were up-to-date with their mandatory training. However, we were shown the training records which showed whilst 91% of staff had received health and safety training, only 64.7% had received fire training, 72.5% had received information governance training and 87.3% of staff had received conflict resolution training. Additional mandatory training was arranged for staff depending on the needs of their role. As an example the immunisation team had been training on resuscitation and anaphylaxis.
- Staff told us they were encouraged to share knowledge and experience with colleagues and funding was available for external courses as part of their continuing professional development. We saw evidence that this took place via the minutes of staff meetings. An example of this was from the school nurses and the training they had received on child sexual exploitation.

Assessing and responding to patient risk

- Risk assessments were completed and evaluated. Staff had undertaken training in completing risk assessments and where required individual risk assessments were placed in patient records.
- The immunisation team had emergency equipment with them during immunisation clinics in the event of an adverse reaction to an immunisation. We observed a clinic take place in a secondary school. Equipment was checked before it was taken out to the school to make sure it was working and the medicines and vaccinations were in date and were at the correct temperature. Consent forms and information about the immunisations were sent to parents in advance. Parents were able to contact the immunisation team if they had any questions. Parents returned completed consent forms to the school and these were checked by the nurses with each pupil before any immunisations were given. Full explanations were given to each pupil and where any doubt existed about the information contained on the consent form the immunisation nurses had to hand, contact would be made with the pupils' parents / carers. We saw staff react quickly to pupils who felt faint or nauseous following their immunisation and had measures in place to monitor pupils' well-being during the clinic. All the staff had been trained in emergency procedures should any of the pupils suffer an allergic reaction.
- We saw that where risks were identified, staff documented these on the electronic patient record system. All the staff had access to these shared records which improved the staff's knowledge of each individual child they were involved with. Staff gave us examples of where this shared access to a child's records had improved their coordination of their care. Specialist children's nurses were able to see what other staff, such as the health care assistants, had written. This helped them determine the nature of the care a child might require.

Good

Are services safe?

- We observed where school nurses worked in conjunction with teachers to assess the risk young people who self-harmed. This involved meeting regularly with key teaching staff to discuss how individual children could be helped and supported.
- We saw staff giving advice to parents on how to recognise and respond appropriately to changes in their child's condition. Information was given to parents verbally, but this was supported by written information in the child's care plan. Parents had direct access to the relevant specialist nursing teams such as the children's community team. They had access to specialist advice and support from the local regional children's centres in Oxford and Bristol.

Staffing levels and caseload

- Health visiting had seen dramatic changes in its establishment and staffing levels A review of the service in 2011 found that health visiting numbers needed to increase in Gloucestershire by 60% over three years. This had been achieved. This increase in staff had resulted in a case load of approximately 50[SS1] children per health visitor. Health visiting had a corporate caseload which staff told us worked well. They told us caseloads were distributed fairly. This meant that when new children were referred to the service, they were not automatically added to one health visitor's caseload. The child was allocated to the most appropriate health visitor team based on where they lived. Each week the health visiting teams meet to discuss new referrals to make sure they are distributed fairly amongst the team, but also so the needs of the child and family are matched by the skills of the health visitor.
- There were three vacancies (1.9 WTE) within the Tewkesbury school nurse team. From an establishment of five (3.89 WTE) there were two staff in post. As a result of the staff shortage in the Tewkesbury team the school nurses had to stop the routine drop in sessions held in secondary schools for appropriately five weeks prior to our inspection. This was because they had to prioritise any safeguarding issue and self-referral needs. The school nursing team provided a service to over 100,000 school children in Gloucestershire. Each school nurse had both primary and secondary schools allocated to them. Secondary schools had regular drop in sessions arranged each week. Safeguarding referrals and self-referrals were seen as a matter of priority. Routine referrals took on average four to six weeks to be seen by the school nursing team. Each referral was risk assessed to decide on its priority.
- The children's complex care team provided children with disabilities with pre-planned short term care in their own home. The team was managed by one complex care coordinator who oversaw the delivery of this care. During our inspection we were told that one person acted as keyworker for all 19 children which included the training and supervision of the healthcare assistants and for arranging the rotas. A team of health care assistants provided the actual care to the child in conjunction with the child's parents / carers. Any specialist care that a child needed was provided by the children's community nursing team.
- Speech and language therapy (SALT) scored each new referral which gave an indication of how much input each child would need. A child would score one if they needed very little input or were ready for discharge from the team, or given a score of three if they had a learning difficulty statement. Currently the case load for speech and language was high, but they constantly reviewed their care pathway to make sure they were current, evidence based and manageable within their current resources. The team had a caseload of 4,341 children at the time of our inspection and this was managed by 49 staff.
- The children's physiotherapy team managed a caseload of 1,705 children with a staff of 23 staff.

Managing anticipated risk

- Staff managed and recognized risks. For example staff in the children's community service recognised children were being discharged into the community from specialist children's hospitals following the insertion of gastrostomy tubes (tubes inserted into the stomach to allowed food and medicines to be administered). The children's community team were not always informed of the child's discharge and relied on the parents making contact with the team. This posed a risk to the child receiving appropriate follow up care when they went home. An audit was completed to assess the extent of

Good

Are services safe?

the problem and to see where additional measures had to be put in place. An action plan was put in place which included liaising with the children's hospitals to improve communication.

- A lone worker policy was in place and staff were aware of this and made arrangements with their colleagues to ensure the safety of staff working alone. Diaries were kept updated to ensure all staff knew of search other's whereabouts at any given time. Arrangements were also made to contact the office following a late visit so that staff knew they were safe. Staff told us that they did not have personal alarms but told us they felt they had good systems in place to promote their own individual safety.

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

Overall we judged the effectiveness of the service as good. Treatment by all staff was delivered in accordance with best practice and recognised national guidelines. Children and young people were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for children and young people.

Staff skills and competence were assessed and staff were supported to obtain new skills and share best practice. Clinical supervision was in place and comprehensive induction programmes were in place for all specialities within children's and young people's services.

Children, young people and their parents understood what was happening to them and were involved in decisions about treatment and care.

We observed good multi-disciplinary and multi-agency working and young people were supported when transitioning to adult services.

Staff understood consent issues especially Gillick competencies and we observed good communication between staff, young people and their parents around consent to specific procedures.

Evidence based care and treatment

- Policies and guidelines were developed in line with national guidelines. These included the National Institute for Health and Care Excellence (NICE) guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. As an example, the safeguarding policy was in line with national safeguarding standards and the local safeguarding procedures with the multi-agencies involved. Other examples were the guidelines for 'paediatric gastrostomy' and the patient group directives for the immunisation and vaccination service.
- The children and young people's service provided all the core requirements of the Department of Health's healthy child programme. This includes early intervention, developmental reviews, screening, prevention of obesity and promotion of breast feeding.
- The stammer care pathway used by the children's Speech and Language Therapy Service (SALT) contained a pre-school stammering assessment which assisted staff to identify risk factors for persistent stammering. This was an evidence based pathway which recognised identifying stammering early reduces the risk of it persisting into adulthood. Two different pathways were used, one for pre and school aged children and another for teenagers.

Pain relief

- Where necessary children's pain was assessed using a variety of methods suitable for children and young people. For instance using smiley and sad faces for younger children. There was guidance in care plans about pain management for children where it was appropriate.

Nutrition and hydration

- Where required we saw guidance around a child's nutritional needs were recorded in their individual plan of care.
- We observed a speech therapist's feeding assessment of a child who was attending a local nursery. The visit was arranged to coincide with the lunch break and the child was observed eating a packed lunch thereby enabling the therapist to make an assessment of the safety and suitability of foods.
- The trust had a target of 95% for recording breast feeding status at the six to eight week check, We saw evidence the trust was meeting and exceeding this target at 98%. Another target was to encourage parents to continue to breast feed from two weeks to six to eight weeks. The target was 80% and the trust was meeting and exceeding this target at 88%.

Technology and telemedicine

Good

Are services effective?

- In December 2014 the children's and young people's team moved onto a new electronic patient administration system. During the roll out of the training programme staff were provided with laptops to enable mobile working. However, in parts of the county there a connectivity problem with mobile signals. Staff overcame this by using Wi-Fi services at GP practices. Other staff knew where appropriate mobile signals could be accessed and others would wait until they returned to the main office base to complete care records. Staff offered telephone support where necessary, this was especially evident for the health visiting team and therapy teams. As an example, a speech and language therapist told us that they would provide the parents with a contact number so they were able to discuss any assessment that had been undertaken with their child at school.

Patient outcomes

- Clinical pathways were in place and gave clear and consistent guidance across the therapy services. Outcomes were measured to ensure that the needs of children and young people were being met in the service.
- The trust scored above the England average for the children receiving appropriate immunisations. As an example, 97.5% of appropriate children had received the triple vaccination (Dtap / IPV / HiB) compared to an England average of 96.3%.
- Audits were carried out to monitor performance and maintain standards. We saw evidence that at least one clinical audit was carried out each year that was relevant and timely to the therapy service. There were ongoing record keeping audits across all therapies; parent child interaction, triage and outcome audits in speech and language; sling provision audit in occupational therapy and exercise compliance and spasticity audits in physiotherapy.
- The children's occupational therapy team reviewed their service for children with Autistic Spectrum Disorder (ASD) and learning difficulties to improve their experience.
- The trust was failing to meet the target for children in year six of primary school to have their height and weight recorded This had been a result of historical poor staffing. We saw that action plans were in place to address this. We were told that the statistics were recorded in a school year (September to July) rather an a financial year (April to March). We saw that the trust was in line to meet the target by the end of July 2015.

Competent staff

- Health visitors had a preceptorship programme in place for newly qualified staff which extended for six months. As part of this programme, staff were given protected learning time and were allocated a preceptor with whom they had regular meetings. The programme also included a range of competencies each member of staff had to complete before they could practice independently...
- The school nurses received a comprehensive induction programme with core competencies they were required to achieve before being able to work alone.
- The allied health professionals received clinical supervision using reflective practice. This took place on an individual and group basis every three months.
- All the staff we spoke to during this inspection confirmed they had received regular appraisals and supervision. The figures provided by the trust up until June 2015 showed a compliance rate of 83.5% for the whole of children's and young people's services against a trust target of 95%. Individual team rates were as follows:

- Home safety team 100%
- Neonatal hearing screening team 100%
- Health visiting 79.49%
- School nurses 85%
- Immunisation team 88.89%
- Safeguarding nurses 92.31%
- Community children's nurses 76.92%
- Children's complex needs team 73.91%
- Physiotherapy team 96.30%
- Speech and language team 96.23%
- Occupational therapy team 94.29%

- The speech and language therapy team told us they had regular appraisals which included the appraisal itself and three informal discussions throughout the year where performance and development could be discussed. Clinical supervision also took place which offered staff opportunity to learn from each other and discuss areas of concern.

Good

Are services effective?

- There was a clear framework for therapy clinical supervision through one-to-one, group and managerial supervision. Most staff were aware of the trust policy for clinical supervision and the supporting documentation for summarising their supervision and the resulting action plan. Staff we spoke with were positive about the quality and the frequency of clinical supervision they received. Staff also said that if they felt they needed additional support this would be requested and provided.
- Additional training needs were identified through supervision and performance reviews. Staff were encouraged to look at their training needs depending on their role and duties and were supported in doing this by the trust.
- There was a commitment to training and education within the therapy services. Staff told us they were encouraged and supported with training and that there was good teamwork. There was a trust wide electronic staff record where all training attended was documented. Managers also maintained a training matrix for their teams at a local level.

Multi-disciplinary working and coordinated care pathways

- We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment. Staff told us they were proud of the integrated work across all disciplines.
- The health visitor and school nursing teams worked in partnership with others on a daily basis, including GPs, social services, midwives and schools.
- Care was coordinated through the use of integrated electronic records that staff had access to. As an example, a school nurse seeing a child was able to see the notes from the health visitor and the GP which helped to inform the care that was needed for that individual child.
- There was proactive engagement with other health and social care providers and other bodies to co-ordinate care and meet the needs of children and young people.

Referral, transfer, discharge and transition

- Children and young people services shared information with GPs other healthcare professionals and where appropriate other agencies such as education either via the electronic patient records system or via reports or verbal / written communication.
- Where children needed specialist support, protocols were in place to make sure appropriate referrals were made. We saw evidence that referrals and discharges were fully discussed and agreed with parents / carers and where possible the child or young person.
- When children and young people received care from the therapies or children's community team they were discharged when they no longer needed intervention. Children seen by the health visitor were transferred to the school nurses at the age of five years.
- The children's community nursing team worked with young people who were transitioning to adult services to help them prepare for the change, to answer their questions and to provide emotional support. Where necessary staff also worked with an individual child's specialist centre such as the Bristol Children's Hospital to support transition[SS1] .

Access to information

- Staff reported the trust intranet was a good forum for communication and links between groups. Information was distributed to staff by global email. Staff told us they had access to individual children's notes as well as clinical guidelines and protocols via their laptops and mobile working.
- Records were stored securely at either staff bases or electronically. The use of mobile working and electronic records reduced the to need for paper based records and reduced the risk of paper records becoming lost when being moved from clinic to clinic.

Consent

- Throughout the inspection we observed staff asking children and young people for their consent. Staff were aware of Gillick competencies and gave us examples of how consent was used. For example the immunisation team obtained consent before clinics from pupils' parents. This was checked with the pupil during the

Good

Are services effective?

clinic and their consent was also sought. Where pupils suddenly refused, their wishes were respected and discussed privately and / or with parents depending on the needs and wishes of the young person.

- We saw examples of school nurses informing pupils in the school that their conversations were confidential unless there were safeguarding issues or if the pupils gave their permission for the school nurses to approach others. We observed this practice occurring.
- We saw a consent form being completed during an assessment and saw where forms had been scanned onto the electronic system. Staff told us they always gave children and young people choices when they accessed their service and we observed during clinic sessions staff discussing the treatment and care options available.

Good

Are services caring?

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

Summary

We have judged the care given to children, young people and their families as good. Parents, carers, children and young people were treated with compassion and respect. Feedback from children, young people and parents had been positive and they were happy with the care provided by the staff.

We witnessed positive interactions between staff and children, particularly when explaining what was happening to them and the treatment plans. Parents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encouraged to be as independent as possible.

All parents we spoke with felt they had enough information about their child's condition and treatment plan. They praised the way the staff really understood the needs of their children, and involved the whole family in their care.

Compassionate care

- During our inspection we observed children, young people and their parents being treated with dignity and respect at all times.
- In February 2015, the trust launched "the "hello my name is…" campaign with staff. This focused on making their initial personal contact with a service user and staff introducing themselves by name, making a personal connection. Throughout our inspection we saw staff being part of this campaign. Staff wore name badges and we observed how they always introduced themselves to the child, young person and parents.
- The NHS Friends and Family Test had been introduced during the last year. Questionnaires were also available for children and young people or their parents to complete. Feedback showed parents found the staff to be efficient and friendly and would recommend the service to family and friends. Although the response rate was low (0.7% in child and young people's services), those that did respond (61) from April 2014 to March 2015, 95.1% said they would be either extremely likely or likely to recommend the services to others.
- We saw the children's physiotherapy team, speech and language therapy team, children's community team and occupational therapy team scored 100% during April and May 2015 for those that would be extremely likely or likely to recommend their service. The health visiting service scored above 90% for April and May 2015
- We accompanied some staff including health visitors on home visits. We observed how one health visitor took extra time and care to make sure the mother understood the purpose of the visits and the information given. We saw that all the staff we accompanied were extremely friendly and professional at all times.
- We observed staff taking time to talk to children in an age appropriate manner and involved and encouraged both children and parents as partners in their own care.
- The feedback we received from parents we spoke to was consistently positive about the care their children received. One parent told us the therapists had been "very supportive "and were "brilliant communicators." Another explained that "the staff are very kind and understanding." A child told us "It's nice here … I do colouring and play with toys and I can get dressed now after PE at school".

Understanding and involvement of patients and those close to them

- Parents told us that staff always involved them in decisions about care and treatment for their children. We observed good examples of how staff involved children and young people as well as their families.
- We observed health visiting baby clinics. This showed excellent communication and interaction between the staff and the mothers. Staff knew the parents, their backgrounds and their needs. Health promotion messages and advice were given such as weaning, sleeping and feeding.
- Therapy staff we spoke with explained how they worked with children and parents. They said they tried to ensure parents and children were fully involved and as informed as possible about their care and treatment. Parents we spoke with were positive about this aspect

of the service. Two parents we spoke with explained how they had always been kept informed of options about treatments. Another parent described how the therapists tried to explain as much as possible to the child about the treatment they were receiving.

Emotional support

- Parents told us they felt supported emotionally by staff. We observed staff providing emotional support to children, young people and their parents during their visit. A parent who had received support from the therapy staff said they were always available for support and advice. They told us "They are always positive and never give up on treatment".
- During our inspection we observed excellent support being given by staff. For example, some pupils were apprehensive about the injection during a school immunization session. Staff were seen providing support and explanation in a way the young person could understand. They supported the individual to eventually have their immunisation. Staff were also alert to the individual needs of each young person and explained a separate appointment could be made to accommodate children and young people who were scared.
- School nurses ran drop-in clinics at secondary schools in Gloucestershire. These enabled young people to get emotional support on any issue that worried them. It also enabled them to be signposted to other services as appropriate.

Good

Are services responsive to people's needs?

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

Summary

The service responded well to the needs of children, young people and their families.

Services were designed to meet the individual needs of children and young people and were delivered in a flexible way at locations to suit them and their parents. These included schools, clinics, local children's centres and visiting children in their own home.

Staff understood the different needs of the children and young people and attempted to ensure that services were as flexible and accessible as possible to the widespread community.

We observed staff respecting and valuing the individual rights and diversity of the children and/ young people they cared for.

Specialist services were in place for looked after children, and a team was available to advise parents on home safety to reduce accidents in the under-fives within the home.

Parents told us they were aware of how to raise concerns or make a complaint. Staff also had a good understanding of these processes and how to deal with them appropriately. Staff actively invited feedback from children and their parents, and were very open to learning and improvement.

Planning and delivering services which meet people's needs

- Staff were committed to delivering services as close to home as possible, minimising disruption for children and their families. Staff visited children and young people in their own homes or in local clinics, schools and nurseries, with some services moved into local children's centres and clinics to make ensure they were more accessible to the local communities.
- We observed the school immunisation team give immunisations at a secondary school. The nurses had, where possible, spoken to parents to determine whether water and, if necessary food could be provided. We also observed the nurses talking to the individual young people and offering advice on what they needed to do following the injection.,
- We spent time with the speech and language therapists in a primary school. The visits had been pre-arranged with the parents and the school. Various children were seen from different classes. We observed excellent interaction between the therapist and the child; the assessments were planned and adapted to the child's needs and their concentration span. Assessments were broken up into sections with games in-between to maintain the child's interest and to make sure the assessments could be completed. The therapist understood the needs of each child before their assessment and had everything ready that they needed. We observed a multi-disciplinary postural management assessment in relation to the postural needs in sitting and sleep positions. This was provided in clinic and home settings, and ensured the child and their family had access to the full team who could work with them to manage posture and provide an individualised plan.
- We observed an occupational therapy adaptations peer review meeting. Complex cases were discussed that required major housing adaptations to meet the needs of a child or young person. Therapists explained that following their assessment of the child's requirements a plan was devised by an architect and surveyor. Occupational therapists from each locality met regularly to consider the plans. This ensured that they could assess whether the plans met the needs of the individual child and provided equity for all applications for grants across the county.

Equality and diversity

- Children, young people and their parents/carers were asked about spiritual, ethnic and cultural needs. Staff delivered care to reflect these needs, . Where English was not the first language, staff had access to interpreting and translation services.
- The areas we visited were accessible to disabled people with regards to access into the building and facilities they were able to use such as appropriate toilets, and where lifts were not available, ground floor consultation rooms.

Good

Are services responsive to people's needs?

- Staff received equality and diversity training as part of their mandatory training. 84.5% of staff had received this training against at trust target of 95%. Plans were in place to make sure those that had not received the training had dates in place.
- We saw evidence that each individual child and family were respected in terms of their cultural and religious backgrounds. As an example, prior to an immunisation clinic at a secondary school, a family who were observing Ramadan were contacted to see if any other provisions needed to be made for their child.

Meeting the needs of people in vulnerable circumstances

- Children and young people were seen in dedicated clinic areas. Staff took measures to provide toys and equipment to distract children and make sure they felt comfortable.
- The specialist home safety team worked closely with other professionals within children and young people's services to make sure children under five within Gloucestershire were protected as much as possible from accidents within the home. The trust recognised that accidents in the home were the greatest cause of injury and death in under-fives. The home safety team were specially trained to recognise dangers, advise parents and carry out safety checks within the child's home.
- The children in care team provided specialist services to children looked after by the local authority. Health assessments were offered to all young people in care. Training and advice was also provided to all professionals working with children and young people in care in relation to their health needs. The team worked closely with the local authority, schools and foster/adoption services.
- The health visiting service provided additional services to children and families in difficult circumstances. This was flexible depending on the needs of the family. This additional support could be due to safeguarding concerns, or simply because the family situation had changed and the parents needed extra support to help them cope with changing circumstances.

Access to the right care at the right time

- To improve access into the occupational therapy service and to meet the two week target identified by commissioners, the team had implemented a new way of working from point of referral to discharge. On receipt of a referral, children, young people and their parents were invited to attend an access clinic to ascertain their occupational performance needs. Weekly clinics were available and enabled the child's occupational needs to be explored and identified more fully than provided on the referral form. This enabled a more thorough assessment of needs to be undertaken.
- A survey was conducted in May 2014 to understand the overall satisfaction and experience of children, young people and their parents accessing the clinics. Parents suggested more telephone consultations. As a result the team increased the number of telephone consultations available during a clinic. Staff told us they were continually looking at ways of improving the service. One parent told us their child had been seen in the access clinic within ten days of the initial referral. They were now attending the Gloucestershire FIZZY programme, which was a school based programme designed by the service to address co-ordination difficulties. Another parent told us that they had been "impressed by the option of a telephone consultation" which meant that they did not have to take time off work.
- A telephone triage system in physiotherapy was in operation every day. Physio Direct enabled parents to talk to a qualified physiotherapy about their child's presenting problem following an initial referral from their GP or consultant. An exercise plan or an appointment to attend a clinic assessment was arranged. A parent told us "we only had to wait for three days for a telephone call and a clinic appointment has been arranged for next week. I'm really impressed … what a brilliant service." Another told us they "felt reassured and less anxious" about their child's condition as a result of their discussion with the physiotherapist.
- The new-born hearing service provided screening to all new-born babies registered with a GP in Gloucestershire when the baby was between 11-14 days old. Where babies had been discharged from the neonatal intensive care unit, a specialist health visitor would arrange to see the baby at home as necessary.

Good

Are services responsive to people's needs?

- Therapy services were meeting their referral to treatment targets (RTT). As an example the trust had a target of 95% of children referred to the speech and language therapy services to be seen within eight weeks. The trust was meeting this target, being at 99% at the time of our inspection[SS1] .

Learning from complaints and concerns

- Parents knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met. Leaflets about making complaints were available in the clinics we visited.
- Staff encouraged children, young people and their parents or carers to provide feedback about their care and questionnaires were available in clinics asking parents to indicate how likely they were to recommend services to friends and family.
- Staff were aware of complaints that had been made and any learning that had resulted. They were able to explain what they would do when concerns were raised by parents. Staff told us that they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy, they would be directed to the trust's complaints process.
- Between April 2014 to March 2015, the trust overall received 6378 complaints and 428 concerns (issues that staff had been able to deal with quickly before they became formal complaints). Within children and young people's services, there were five complaints and 24 concerns. The concerns mainly focused on communication (10), clinical care (7) administrative errors (6) and waiting times (1). The complaints were primarily about health visiting (3), speech and language therapy (1) and physiotherapy (1).

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 have judged the leadership of the children and young people's service as good.

Good local leadership was provided throughout the various teams and staff were particularly complimentary about the support they received from the locality managers and lead therapists.

Frontline staff and local managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.

Most staff were positive about working for the trust. Staff took pride in their work and being at the centre of the community. They wanted to come to work.

Children and young people were able to give their feedback on the services they received and this was recorded and acted upon where necessary.

Service vision and strategy

- The trust had four values of caring, open, responsible and effective. Staff had a good understanding of the trust's core values and were proud of the service they provided.
- Overall the vision of the children and young people's service was to place the child, young person and the family at the heart of the service. All the staff we spoke with during the inspection confirmed this. We saw evidence that this ethos was reflected in their practice, and in the feedback from children, young people and their parents or carers.
- Each individual specialty within children and young people's services had their own vision, such as the school nursing team whose vision was to provide a service that was visible, accessible and confidential. The staff we spoke to had a good understanding of the trust vision and strategy, the vision for children and young people's services and also their local specialist vision.

Governance, risk management and quality measurement

- Child and young people's services was split into six localities (Stroud, Cotswold's, Tewkesbury, Cheltenham, Forest of Dean and Gloucester). Each locality was managed by a locality manager who was operationally responsible for all the community teams within that locality such as health visitors, school nurses and therapists. Each of the locality managers also took a service role responsibility for each individual service.
- The non-executives of the trust undertook regular quality visits with staff. In March 2015, one of the non-executives attended a secondary school with the immunisation team. They commented that they were impressed by the efficiency and kindness of the staff. It was also noted that the comments from the children being immunised were very positive. We saw that these visits were reported to the trust board. We noted that visits had also been completed with the physiotherapy team.. The children's community team were due for a visit in September 2015.
- We reviewed the risk register for children and young people's services. This had seven risks listed including chlamydia screening, , appraisals for staff and mandatory training for staff. The risks present on the register had details of when they were added, controls that were in place to mitigate the risk, the lead manager responsible together with updates and review dates. We noted that the staffing issues within the Tewkesbury school nurse team had not been added to the risk register. We asked why this was the case and were told that because they had taken steps to mitigate the risks and had now appointed staff it was felt unnecessary to add to the risk register. When staff identified risks, it was initially discussed with their line manager and then at a trust wide level through the governance committee meetings.
- Staff attended a number of regular meetings. There was wide participation in community governance meetings with all therapies having a clinical governance group.
- Minutes were available for bi-monthly clinical governance meetings where governance, safeguarding, performance and audits were discussed.

Good

Are services well-led?

- We saw that regular auditing took place with evidence of improvement. Children and young people's services had completed 16 audits during 2014/2015. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results. These results were monitored at the clinical governance and staff meetings for each professional group. This was reflected in the minutes of those meetings.
- Each professional group had their own governance forum or development group meetings. These fed into the overall governance group for children and young people's services. This in turn reported to the scheduled care forum and onward to the trust board.
- There was a clear structure for clinical governance in therapy with regular bi-monthly meetings attended by a core membership of therapists. We saw minutes from these meetings which showed that issues affecting the service were discussed and actions taken.

Leadership of this service

- Staff told us the chief executive and senior management team visited the community sites and made a real effort to find out about the service and strengthen links with the wider community services.
- The trust ran a programme called 'Listening into action" as a way of empowering staff to make changes within their service to improve the quality of care for patients.
- Staff told us they felt well supported by their line managers, particularly during times of change. Managers were described as visible and accessible.

Culture within this service

- The staff we spoke to during the inspection told us they were proud to work in the community team and were passionate about the care they provided. Staff told us there was an "open culture" and they felt confident about raising concerns. They felt their "voice was heard".
- Staff were positive about working for the trust, although at times they told us they felt stretched and under pressure because of the volume of their caseload. They were continually being challenged to streamline and prioritise their workload and sometimes felt that senior managers did not always take into account the complexities of their specialist therapy roles and involvement in complex social care processes.
- Managers we spoke with told us they were proud of the staff they supervised and that there was a high level of commitment to providing quality services to the community. One manager told us their team was "dynamic and "constantly rose to the challenges of change." They were most proud of the "incredible quality of care" their team provided.

Public & staff engagement

- We saw there were systems in place to engage with the public and staff to ensure regular feedback on service provision for analysis, action and learning. In addition to the Friends and Family Test, questionnaires were used such as within the school nursing team to gauge how useful the pupils found the service.
- Staff were aware of the trust whistleblowing policy and felt confident about using this process if required.

Innovation, improvement and sustainability

- Staff were clear that their focus was on improving the quality of care for children, young people and their families. They felt there was scope and a willingness amongst the team to develop services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12: Safe care and treatment: 12(2)(g) the proper and safe management of medicines.** **The provider did not have systems in place within the complex care team to make sure medicines were administered safely to children. Medicines were drawn up by parents, left in unlabelled syringes ready for health care assistants to administer. This meant the staff were not confident in what medicines they were actually administering. This put the child at risk of receiving inappropriate medicines or doses.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12: Safe care and treatment: 12(2)(g) the proper and safe management of medicines.** **The provider did not have systems in place to secure and audit how external prescriptions were used within the health visiting teams. Systems did not exist to safely monitor these prescription forms to prevent their misuse.**