Lincolnshire Community Health Services NHS Trust

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Community health services for children, young people and families

Quality Report

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

Summary of findings

Ratings

Overall rating for Community health services for children, young people and families	Requires Improvement
Are Community health services for children, young people and families safe?	Requires Improvement
Are Community health services for children, young people and families effective?	Good
Are Community health services for children, young people and families caring?	Good
Are Community health services for children, young people and families responsive?	Requires Improvement
Are Community health services for children, young people and families well-led?	Requires Improvement

Summary of findings

Contents

Summary of findings

Overall summary

Community health services for children, young people and families included a range of services. During our inspection we reviewed the health visiting service, the school nursing service, the vulnerable children and young people's team, the family nurse partnership service, therapy services and community dental services.

We spoke with 45 health visitors and support staff, 40 staff from school nursing teams, 14 therapists, six members of the family nurse partnership team (FNP) and four staff from the vulnerable children and young people team (VCYP). We also spoke with the general manager, the head of clinical services, and a locality manager and three deputy named nurses for safeguarding.

We spoke with 25 parents who were either accessing services during our inspection or by telephone. We accompanied staff on four home visits. We received 43 CQC comment cards which had been completed by parents prior to or during the inspection.

Staff told us due to issues with connectivity they were unable to access records within patient's homes. Most of the staff we talked with was positive about the use of an electronic records system although they felt that it took longer to complete record keeping. This was because they had to make hand written notes during the contact and then record the information electronically within 24 hours. During our inspection we found the numbers of health visitors working in the service and their case load sizes did not match the number provided to us before the inspection. The trust had an active programme of development to increase the number of Specialist Community Public Health Practitioners (SCPHN) within school nursing. However at the time of the inspection the school nursing service was not working within the DH recommendations from Choosing Health or CPHVA guidance of one qualified school nurse for every secondary school and their cluster of pyramids.

The Healthy Child Programme was delivered through skill mix 0–19 child health teams. The teams consisted of health visitors, school nurses, community staff nurses, nursery nurses, family support workers and health care assistants.

Initiatives such as UNICEF baby friendly were in operation. Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence-based guidance. For example, the trust had just introduced a FNP team. There were formal processes in place to ensure staff had received training, supervision and an annual appraisal. We saw evidence that over 90% of staff had completed the relevant mandatory training.

As part of our inspection we observed care in patient's homes, clinic settings and observed staff speaking to clients on the telephone. In order to gain an understanding of people's experiences of care we talked to 25 people who used services in the family and healthy lifestyles business unit. Staff told us they were passionate about delivering high quality patient centred care. The majority of people we spoke with were generally happy with the care they had received. Throughout our inspection we found members of staff treated children, young people and families with dignity and respect. Parents told us they felt respected, well supported and that staff were always polite and helpful with any concerns they may have. We found all staff we spoke with were child and family focused and offered support to help children and parents cope with their care and treatment.

We identified gaps in commissioned services within school nursing for children and young people who had urinary wetting in the daytime or faecal continence concerns. In addition there was no current system in place to identify children who were not in education for example being home schooled. A lead role had been introduced to look at this however there was no timescale for when this would be achieved. Staff in school nursing particularly raised concerns about how responsive they could be to meet the needs of children and young people as staffing capacity did not allow them to be as flexible as they needed to be. Staff within all therapy services were meeting the 18 week referral to treatment times however patients sometimes had to wait long periods to seen at a follow-up appointment.

There was confusion over the number of health visitors actually working within the health visiting service and having face to face contact with children. During our inspection we found there were large differences between the caseload numbers health visitors were

Summary of findings

working with. We asked senior managers about this who confirmed staff had not been deployed in the 'right places' across the health visiting service. They were aware this was something they needed to address but were unable to show us firm plans of when and how they would implement this across the trust at the time of the inspection.

Within the school nursing service staff told us they had very little flexibility to meet the needs of children and young people for targeted interventions. The school nursing service was commissioned to deliver interventions on the academic timetable and for children and young people with additional needs but this tended to be safeguarding work. Staff also told us they anticipated it would be difficult to be flexible as some children and young people needed more input than others and this was down to individual need. School nursing staff felt they were limited in the health promotion work they could undertake.

Summary of findings

Background to the service

There are approximately 143,323 children aged under 19 living in the Lincolnshire area which accounts for approximately 19.8% of the population. The health and wellbeing of children in Lincolnshire was mixed compared with the England average. Infant and child mortality rates were similar to the England average. The child health indicators for Lincolnshire show that ten indicators were significantly better than the England average, seven worse and fifteen were not significantly different.

Community health services for children, young people and families included a range of services delivered in the Lincolnshire area. Core services included health visiting, school nursing and therapy services. These services were complemented by specialist teams. The teams consisted of health visitors, school nurses, community staff nurses, nursery nurses, assistant practitioners and health care assistants.

Our inspection team

Our inspection team was led by:

Chair: Stuart Poynor, Chief Executive, Staffordshire and Stoke on Trent Partnership NHS Trust

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; school nurse, health visitor, GP, nurses, therapists, senior managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Lincolnshire Community Health Services NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Lincolnshire Community Health Services NHS

Summary of findings

Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 9 and 11 September 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 23 locations which included 4 community inpatient facilities and one walk-in centre. We carried out an unannounced visit on 10 September to one of the inpatient units.

What people who use the provider say

Most of the parents we spoke with and the comment cards we received all indicated how involved and supported they felt by staff within the services. Parents told us they felt respected, well supported and that staff were always polite and helpful with any concerns they may have.

These are some examples of what people told us:

- Within the community dental services one person told us they had a phobia about dentists and this service "had made a big difference to them."
- One parent told us "their HV had been fantastic and had been very supportive."
- School staff we spoke with told us they were very happy with the school nursing service and the support they received from the service though they "would like more."
- One parent whose child was using therapy services told us "all the staff show a genuine interest and care."

We spoke with one parent whose child used all the therapy services. They told us the physiotherapist was their key worker and had provided a written therapy programme and co-ordinated care and feedback with the other therapists. However other parents we spoke with within therapy services had mixed views on how involved they had been in their child's care. Some parents felt they had not been involved as much as they could be. One parent told us "we currently don't have a physiotherapist so we are waiting without communication to find out what happens next."

We saw the results of a health visitor survey in the South East quadrant. We saw from the results 77% of people who returned the survey felt they had been involved in decisions about the way in which health visiting services were provided to their child and family.

Good practice

- The health visiting service had developed a breastfeeding website so parents were able to access support and guidance 24 hours a day seven days a week.
- Within school nursing services they had undertaken safeguarding pilot to support school nursing services in managing the health needs of vulnerable children and young people. The pilot involved the development of a robust evidence based process with pathways.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure the lone working policy is implemented across children's services.
- The trust should ensure there are effective systems to manage and monitor activity which could not be undertaken due to capacity issues.
- The trust should review their staffing risk assessments to ensure there are robust processes in place to manage risk.

Summary of findings

- The trust should ensure staff resources in health visiting and school nursing are appropriately allocated across the trust.
- The trust should ensure in school nursing they have sufficient resource to meet the needs of children and young people who require additional support above the contacts offered in the academic timetable.
- The trust should review the waiting lists in school nursing services to ensure the needs of children and young people are met in an appropriate timescale.
- The trust should review the provision of services to children and young people with daytime urinary wetting and faecal incontinence.
- The trust should review the provision of services to children not in education, employment or training.

Lincolnshire Community Health Services NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

The five questions we ask about core services and what we found

Requires Improvement

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

By safe, we mean that people are protected from abuse

Incidents, reporting and learning

There were systems in place to report incidents. Staff reported they knew how to report incidents and usually received feedback from these. However staff told us they did not routinely report near misses. Near misses are incidents that happen that did not result in injury, illness, or damage but had the potential to do so.

There had been 395 trust wide serious incidents between June 2013 and May 2014. Five of these incidents related to child abuse. We saw information which showed the trust had undertaken a root cause analysis in each case which highlighted lessons learnt and contributing factors. A root cause analysis (RCA) is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned to prevent the same incident occurring again. Action plans had been developed and monitored to ensure actions had been implemented.

For example an action from one serious incident highlighted the need for routine enquiry about domestic abuse at each contact where appropriate to do so. Staff told us how they had received training and routinely asked domestic abuse questions when safe to do so.

Cleanliness, infection control and hygiene

There were policies and procedures for infection prevention and control. Staff reported they had received infection control training. Health centres and clinics we visited appeared visibly clean. We noted in some baby

Requires Improvement

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

clinics in children's centre's hand-washing facilities were not always easily accessible. In these situations we observed staff utilised hand gel to clean their hands between patients.

Therapy services staff told us infection prevention and control was a "high priority". There was a policy in place for staff in therapy clinics to ensure equipment was cleaned before and after use and a signature sheet to confirm this had happened. Staff told us the family and healthy lifestyles business unit had been using a specific piece of equipment (sleep system) which had been used for different patients in clinic settings. This had proved difficult to clean in line with trust policy so the manufacturer had made a bespoke piece of equipment which could be cleaned appropriately.

We visited the community dental services and observed good infection control practices such as hand hygiene and cleaning equipment between uses. This was another example of how services in the family and healthy lifestyles business unit followed infection control procedures to minimise risk to patients and users.

Maintenance of environment and equipment

The majority of staff told us they had the equipment they needed to perform their roles effectively. We identified that equipment had been serviced and checked according to schedule which was confirmed by members of staff.

However we found at Grantham health centre staff told us they did not have a shredder so they could safely discard of confidential waste. This meant a member of staff had to take confidential waste to another site to be discarded which took them away from their role and base.

Medicines management

We reviewed the management and administration of immunisations by the school nursing teams and judged these were managed safely. School nurses we talked with explained they had received training and demonstrated an awareness of the 'cold chain' to ensure the correct temperature of immunisations was maintained. The refrigerators in the North Hykeham base each had a folder to record the temperatures of the fridges. This enabled staff to monitor and ensure vaccinations were stored within the correct temperature range so they remained safe and effective to use. Staff told us there was a procedure to follow if temperatures varied outside of the manufacturer's guidance and should this occur it would be reported as an incident. Some school nurses and health visitor's had been trained as prescribers and could prescribe medicines such as lotions and creams along with analgesia such as paracetamol.

A patient group direction (PGD) is a document which has been signed and agreed by a doctor and pharmacist and can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. PGD's are used in specific situations such as for infants and children who require immunisations as part of the national programme. We found the school nursing service had PGD's for the Human papilloma virus (HPV), Fluenz vaccination and Levonelle (emergency contraception pill). We reviewed the PGD's and found these were appropriate and in date.

Safeguarding

The trust had a safeguarding team which included named nurses and deputy named nurses who acted as a duty team to give members of staff advice, training and planned supervision. Information demonstrated that across children's and young people's services there were 388 children and young people who were subject to child protection plans. In addition there were 1,556 children who had child in need or team around the child plans in place.

All staff we spoke with were able to explain how safeguarding referrals were identified, referred and followed up. The Safeguarding Children and Young people: roles and competencies for health care staff Intercollegiate document March 2014 stated all clinical staff such as health visitors, school nurses and paediatric allied health professionals require level three safeguarding training. Records we reviewed confirmed they had all received level three training. In some instances staff told us they were being supported to undertake level four training.

Records systems and management

We reviewed a sample of SystmOne's electronic health records within children's and young people's services and found detailed and accurate records. The trust expected members of staff who utilised the system to adhere to a set of record keeping standards, for example, entries had to be made into the system within 24 hours of contact with a child or young person. The electronic records were accessible to other healthcare professionals for example the patient's GP and information was recorded in a

chronological order. Staff were able to put markers on the healthcare record to alert other staff to certain information for example children who were subject to child protection plans.

Within the vulnerable children and young people's (VCYP) team they utilised an electronic record to manage, monitor and support the health assessments for looked after children and young people. The records recorded the date the assessment was due, when it was completed and when the next assessment was due. It also contained details of when the assessment had been sent to the social work team. Staff told us this helped them make sure children and young people had their health assessment at the relevant time.

Due to issues with IT connectivity staff told us they were unable to access records within patient's homes. Most of the staff we talked with was positive about the use of an electronic records system although they felt that it took longer to complete record keeping. This was because they had to make hand written notes during the contact and then record the information electronically within 24 hours. The general manager and management team were aware of the issues and the trust had identified the connectivity issues as a problem area they needed to resolve.

We saw results of a record keeping audit undertaken in 2013. An action plan had been developed to identify areas and actions services in the family and healthy lifestyles business unit needed to improve on. For example improved recording of child protection or safeguarding issues within the electronic health record.

Lone and remote working

The trust had a lone working policy which detailed the minimum precautions staff should make when lone working in community settings. Staff told us they used electronic diaries which reflected the visits they would be undertaking each day and this was accessible to other staff, they were also provided with a mobile phone to aid communication. However we did not see a consistent approach across services to signing in and out of visits or a system for managers to monitor staff whilst out on home visits. These were identified as "must do's" in the trust policy which meant the services were not following the trust's lone-working policy. For example staff within children's therapy teams and school nursing team at Louth told us they did not routinely do this.

Staff told us they had systems in place to respond to risk for example if there were concerns about visiting a family by themselves staff would visit with a colleague or use an alternative venue to the patient's home. Staff reported they were able to put a note on the electronic care record so this would alert other staff members. Staff throughout children's services told us they would use this system to alert colleagues.

Assessing and responding to patient risk

The DASH (domestic abuse, stalking and honour based violence) risk assessment is a tool used to assess the risk that a victim is exposed to and what action may be required. The purpose of the checklist is to give a consistent and practical tool to practitioners working with victims of domestic abuse to help them identify those who are at high risk of harm and whose cases should be referred to a Multi-Agency Risk Assessment Conference (MARAC) meeting in order to manage the risk. Staff within health visiting and school nursing services told us they had received training on domestic abuse and how to use the dash risk assessment which they felt confident to use.

Staffing levels and caseload

Health visiting teams consisted of health visitors supported by community nursery nurses and administration staff. Health visitors have overall responsibility for the caseloads but would allocate packages of care to nursery nurses to undertake. For example a time limited package of care may be undertaken with a child and family by the nursery nurse on behaviour management.

The family and healthy lifestyles business unit provided us with information on their workforce tool before the inspection. The main purpose of the tool was to identify a staffing profile required to meet the needs of the local population and in doing so identify gaps in staffing. The tool took population and dependencies and used this to predict activity levels. The predicted activity levels were then translated to a staffing profile which was then used by locality leads to inform staff deployment and recruitment. This was to ensure teams were adequately resourced to deliver the universal part of the healthy child programme (HCP) and meet individual needs of children within the whole caseload. However we found the mapping tool only looked at activity undertaken and did not capture activity which had not been undertaken due to capacity issues. For example within school nursing some teams operated a waiting list system which was reviewed at

allocation meetings to manage the workload. This meant for some children and young people they may have had to wait longer than usual to receive care. The trust had an incident reporting system. During the inspection we sought information as to whether this system was used to capture incidents where activity had been missed due to resource concerns. During the inspection this information was not available to us. This information has since been provided to us which indicates a range of incidents of missed activity.

Throughout our inspection a common theme emerged from staff who told us they did not understand the workforce tool and how this was used to inform teams and caseload numbers. Staff were also unclear on the actual number of staff which were required for their caseloads.

Where staffing shortages had been identified in one team a risk assessment and actions had been undertaken to reduce the risk. However in other teams where there had been staff shortages we found risk assessments had not been put in place. Actions had been undertaken but these had not been recorded or monitored for effectiveness. We spoke to both the general manager and head of clinical service about this who told us they would expect risk assessments to be in place. Staffing in health visiting and school nursing had recently been added to the trust risk register. We found there wasn't an overall service or unit risk register to capture risks which weren't high enough to reach the trust risk register. This demonstrated there was a lack of consistency in managing risks across the family and healthy lifestyles business unit.

In 2011 the health visitor implementation plan (DH) identified the government's commitment to increase the number of health visitor's nationally by 4,200, to be reached by March 2015. For Lincolnshire community healthcare services this meant there would be an increase to 134.5 whole time equivalent (WTE) health visitors by March 2015 working in the trust. This overall number of health visitors would include health visiting staff in the trust working in other roles and who may not have face to face contact with children. The trust anticipated approximately 120 wte HV's would be working directly in the health visiting service and having face to face contact with children.

We were told by the trust before the inspection that from the 1st September 2014 there would be 115.5 (WTE) Health visitors working in the health visiting service and the current health visitor caseloads were 344 children per wte health visitor. Lord Laming (2009) in his report on the protection of children in England stated health visitor caseloads should be no more than 400 children. The community practitioner and health visitor association (CPHVA 2009) made further recommendations that 400 should be a maximum caseload and 250 was the ideal caseload number for any health visitor.

As part of the health visitor implementation plan the vision was that health visitors would deliver the HCP in its entirety. Due to the current staffing issues health visiting staff told us they were undertaking antenatal contacts (where possible), birth visits and the 6-8 week contact; the remainder of the HCP was routinely delivered by nursery nurses.

We spoke with senior managers including the general manager and the head of clinical services about the concerns over staffing and caseload numbers. There was confusion over the number of health visitors actually working within the health visiting service and having face to face contact with children. During our inspection we found there were large differences between the caseload numbers health visitors were working with. We asked senior managers about this who confirmed staff had not been deployed in the 'right places' across the health visiting service Apart from staff redeployment to the Boston team and further recruitment there was no strategy or process to look at the whole service to ensure staff resources were in the right places. They were aware this was something they needed to address but were unable to show us firm plans of when and how they would implement across the trust. For example;

- North West 1 team (Fen House) had 2,950 children on the caseload and there were currently 5.89 wte health visitors in post. This would increase to 7.69 wte in October with new staff starting. This meant there would be 383 children per wte health visitor.
- North West team 2 (Birchwood) had 1,778 children on the caseload and there were 3.7wte health visitors allocated to this team. This meant there were 480 children per wte health visitor. When we met with the team leader and operational lead they told us two of the health visitors were off sick so this left the team with 1.7wte health visitors. Support was being provided in the short term by staff from other teams.
- South East team 1 (Boston) had 6,194 children on the caseload and there were 6.4 wte health visitors

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

allocated to this team. This meant there were 967.8 children per wte health visitor. Support was being provided in the short term by staff from other teams and there were plans to move additional staff into this team.

- At the focus groups health visitors told us there were discrepancies between the resource mapping and the numbers of children from the GP caseloads. In some cases this was reported as a 50% difference in numbers. Staff reported their caseloads were 700-800 per wte health visitor.
- As of 1st September 2014 there were 39,744 aged 0-4 in the health visitor service. Following our inspection the trust provided further information on the total number of health visitors in universal services. As of 1st October 2014 this would be 83.47wte. This meant across the trust the average caseload sizes per wte HV would be 476 children.

Since the inspection the trust has provided updated information regarding caseload numbers and staffing establishments. In most teams this has meant an improvement in the number of children allocated per health visitor.

There was an active and on-going recruitment programme to recruit health visitors to work within the trust. The General manager told us the health visiting service had recruited 7.6wte health visitors who were due to start within the next 3 months and a further 10 student health visitors had been offered posts when their courses finished in January 2015. All the management team we spoke with were fairly confident the trust would achieve there trajectory numbers in March 2015. The general manager also told us the family and healthy lifestyles business unit were looking at an incentive scheme to try and encourage new staff to join the organisation in particular to the areas they had difficulty recruiting to.

Within the school nursing service staff told us they had very little flexibility to meet the needs of children and young people for targeted interventions. The service was commissioned to deliver interventions on the academic timetable and for children and young people with additional needs but this tended to be safeguarding work. Staff told us if a young person needed some targeted intervention they could offer 4-6 contacts but this could only be done if they had delivered the contacts on the academic timetable. Staff also told us it was difficult to be flexible as some children and young people needed more input than others and this was down to individual need. School nursing staff felt they were limited in the health promotion work they could undertake. Previously they were able to be flexible in the approach they used for example if there had been instances of young people binge drinking they would have been able to undertake a health promotion talk to the whole class rather than just individual care but they were no longer had sufficient resource to enable them to do this.

School nursing teams consisted of school nurses, registered nurses and assistant practitioners. The same mapping tool used in health visiting was also used in school nursing to review activities and match the appropriate member of staff with the skills and competencies to undertake the task. For example a time limited package of care with a young person may be undertaken by a staff nurse on sexual health.

The trust had an active programme of development to increase the number of Specialist Community Public Health Practitioners (SCPHN) within school nursing. Over the previous three years the trust has reduced the deficit of SCPHN's required according to service mapping from 9.2 wte to 2 wte. This has been managed by supporting nurses into training on a full time or part time basis. At the time of inspection there were four SCPHN's in training. The total number of SCPHN's in post was 16.82. There was a current advert for 1 wte SCPHN post at the time of our inspection. According to the resource mapping tool the family and healthy lifestyles business unit required 19.92 wte SCPHN's to meet the needs of the family and healthy lifestyles business unit. We saw the service specification for the school nursing service from commissioners. In this document it stated the school nursing team would comprise of members who had the competency to provide a service that covers all key priorities, as detailed in the service specification. We did not see any information in the specification which indicated how many SCPHN's the service required.

In 2004 the Department of Health (DH) in their white paper Choosing health: making health choices easier committed to the provision of 'at least one full time, year round, qualified school nurse for each secondary school and its cluster of primary schools' (school pyramids).The CPHVA (2013) further recommended there should be one full time public health qualified school nurse (SCPHN) for every secondary school and its cluster of primaries with

additional qualified school nurses or community staff nurses according to health need. We were told by one of the Band 7 SCPHN's there were 84 secondary schools across Lincolnshire.

During our inspection we reviewed the caseloads and staffing establishments. For example;

- In the Louth team there was 1 part-time SCPHN on a 39 weeks a year contract, with a team of staff nurses, assistant practitioners and health care support workers. There was also a SCPHN vacancy within the team. Staff told us there were eight secondary schools and 42 primary schools on this caseload.
- In the Sleaford team there were 2 SCPHN's supported by a team of staff nurses, assistant practitioners and health care support workers. Within this caseload there were four high schools and 21 primary schools.
- At the focus groups staff within the school nursing teams told us they felt they did not have enough SCPHN's to meet the needs of the local population.

This meant the school nursing service were not working within the DH recommendations from Choosing Health or CPHVA guidance of one qualified school nurse for every secondary school and their cluster of pyramids.

The family and healthy lifestyles business unit provided information on what they expected average caseloads for services to be;

- For a band 5 physiotherapist they would have a caseload of less complex children who would be reviewed in clinics. This would equate to approximately 120 children and young people and they would be expected to see 22-25 face to face contacts a week.
- For a band 6 occupational therapist they would have approximately 60 children and young people and they would be expected to see 12-15 face to face contacts a week.
- For a speech and language therapist who had a day per week in a clinic the caseload for that clinic would be 60 – 70. Additional time was put into clinics during school holidays.

Within therapy services staff told us there was no capping on caseloads and there was an expectation numbers would be absorbed by the teams. Staff told us they worked across the different geographical areas of the trust to meet the needs of the service and this sometimes meant they were travelling large distances between contacts.

There were specialist teams within the children's and young people's services which included the family nurse partnership (FNP) and the vulnerable children and young people team (VCYP). The FNP team had been newly established in July 2014 and had recruited to all its positions. The VCYP team had recently increased in the number of staff in the team to support vulnerable children and young people including looked after children.

Consent

Staff were aware of when and how to use Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. Since then, they have been more widely used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions. Staff within school nursing were able to give examples of how they used the competencies. For example staff may use Gillick competency when assessing a young person's ability to give consent for an immunisation. Staff also explained how they would use Fraser guidelines when supporting a young person with the emergency contraception pill.

We saw the results of the record keeping audit from 2013 which highlighted services within the family and healthy lifestyles business unit needed to improve the recording of client's consent to share information from their electronic health record and with whom. This had been identified as action which had been completed by the end of March 2014.

Managing anticipated risks

Before our inspection we requested the family and healthy lifestyles business unit risk registers and were provided with the trust risk register which recorded risks graded at a high level. At the time of our inspection we found the family and healthy lifestyles business unit did not hold a risk register for risks which did not meet the criteria to be put on the trust risk register. This meant the family and healthy lifestyles business unit had no mechanism of recording and monitoring risks which would be managed at service or team level rather than trust wide.

Requires Improvement

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

A risk assessment is a systematic process to review actual or potential risks so services can identify whether they are taking reasonable steps to prevent harm. In one health visiting team a risk assessment had been completed to review and manage staff shortages within that team. However this was not consistently put into practice across the health visiting service. We asked one of the locality managers about staffing shortages in another team and whether a risk assessment had been completed. We were told they were currently completing the assessment the week of our inspection. This meant the health visiting service did not have a consistent approach to managing risks across the trust.

Good

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

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

Evidence based care and treatment

The HCP is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices. The trust provided this service through teams that consisted of health visitors, school nurses, community staff nurses, nursery nurses, assistant practitioners and health care assistants.

Initiatives such as UNICEF baby friendly were in operation. The UK Baby Friendly Initiative was based on a global accreditation programme of UNICEF and the World Health Organization. It was designed to support breastfeeding and parent/ infant relationships by working with public services to improve standards of care.

The health visiting service was currently accredited to level one and the trust indicated the service would be making an application to be assessed against level two with the neighbouring acute trust in 2015.

Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence-based guidance. For example, the trust had just introduced a FNP team. The FNP programme was a voluntary health visiting programme for first-time mothers that was underpinned by internationally recognised evidence based guidelines.

The trust monitored and identified whether they followed appropriate NICE Guidance relevant to services they provided. For example we saw the family and healthy lifestyles business unit was partially compliant with NICE guidance on the management of autism in children and young people within the speech and language therapy service.

Nutrition and hydration (optional)

The health visiting service had four infant feeding co-ordinators to support parents and staff with feeding concerns. The service developed a breastfeeding website which was launched during breastfeeding awareness week in August 2014. The website enabled parents to access support 24 hours a day and gave information on a range of topics. For example we saw there was information on how to express milk and the importance of skin to skin contact. It was too soon after the launch of the website to assess how successful this had been.

There were two lactation clinics which were run weekly within the county by qualified lactation consultants where appointments could be offered to mothers and babies who were experiencing difficulties. Health professionals could refer patients directly if they required specialist support.

Approach to monitoring quality and people's outcomes

We reviewed evidence which demonstrated patient outcomes and performance information was closely monitored and reported by the family and healthy lifestyles business unit. Performance data which monitored compliance with the key contacts within the Healthy Child Programme within the 0-4 age group; for example over 90% of parents received a primary birth visit within 14 days.

The overall rate of babies who had sustained breastfeeding from the birth visit to the 6-8 week contact in the period from July 2013 to June 2014 ranged between 65% to 73.9%, against a target of 74%. The service were using a range of initiatives to improve breastfeeding rates which included a project to look at re-launching breastfeeding groups and all babies and mothers that were breastfeeding received an additional contact at 3-4 weeks of age to offer support.

The delivery of antenatal contacts was recognised as a key core contact providing a foundation for on-going assessment. In the period from July 2013 to June 2014 the health visiting service had only managed to achieve between 6% and 24.95% against a year to date target of 60%. We saw for other key performance indicators the service were meeting targets of above 90%. For example the service met the targets for the number of primary birth visits and the 8 to 12 month contact. When we spoke to one of the locality managers they told us they anticipated the health visiting service would deliver the whole of the HCP when the trust had met the HV trajectory in March 2015.

Good

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

We saw the school nursing service achieved their key performance indicators for height and weight measurements for the national childhood measurement programme (NCMP) and for the delivery of HPV immunisations.

Specialised services such as the VCYP team and the FNP team also monitored indicators to ensure they were meeting their respective targets. For example, within the looked after children annual report 2013/ 2014 there was information the VCYP monitored children and young people to ensure they remained up to date with immunisations. Between April 2013 and March 2014 the percentages of children and young people up to date with immunisations ranged between 85% to 94%.

Competent staff

There were formal processes in place to ensure staff had received training, supervision and an annual appraisal. We talked with a number of health visitors, school nurses, therapists and specialist teams such as the VYCP team and FNP team. All staff we talked with told us they undertook a variety of mandatory training and received an annual appraisal. Staff told us on occasions due to staffing capacity issues they were not always able to access role specific training however mandatory training was prioritised. We saw evidence that over 90% of staff had completed the relevant mandatory training across services within the family and healthy lifestyles business unit.

Staff in school nursing told us they received annual training on immunisations. They also told us there were only two specific days training and if staff missed these days they would not be able to immunise until they received the training the following year. We spoke with the head of clinical service who confirmed this was the current situation but the human resources team within the trust were looking to address this. The general manager told us in the interim staff would be offered bespoke training so they would be able to immunise however staff did not seem aware of this.

Health visitors and school nurses received a minimum of quarterly safeguarding supervisions of their work with their most vulnerable babies and children. Safeguarding supervision was provided by the deputy named nurses. Information provided to us indicated the family and healthy lifestyles business unit monitored compliance with supervision. Information for the number of completed supervisions between April-June 2014 was 94.59% in the north east quadrant. When staff had missed supervision a reason had been recorded, for example if the member of staff had been off sick. Therapy staff told us they received regular group supervision for safeguarding.

Use of equipment and facilities

Staff in therapy services told us they sometimes struggled in clinics because the venue was not suitable for the type of therapy the client was receiving such as occupational therapy or physiotherapy. The therapists used a variety of venues for clinics including children's centres. On occasions they found it difficult to be able to access a regular room and time for their clinics. We saw information which indicated the family and healthy lifestyles business unit were aware of the issues therapy services faced in clinic settings.

Multi-disciplinary working and coordination of care pathways

We were provided with and observed a range of evidence which showed how services worked with other agencies to meet the needs of children and young people. For example we spoke with a local children's centre manager who spoke very positively about working with the health visiting teams to meet people's needs. We observed a health visiting nursery nurse work closely with staff from the children's centre during a child health clinic.

Staff within school nursing had good links with primary mental health workers (child and adolescent mental health services CAMHS) who provided advice and support for children and young people experiencing mental health issues. However should a child or young person need a referral to CAMHS services, staff within school nursing were unable to directly refer. They had to refer the young person to their GP to make the referral.

Within health visiting and school nursing there were identified leads working with other agencies to develop care packages and pathways. For example there was a health visitor working with the local authority to look at school readiness.

Evidence demonstrated multi-disciplinary working at a more strategic level across all children's community teams. For example, the named nurse for vulnerable children and

Good

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

young people attended various meetings and forums which involved multi – agency partners such as the looked after children's steering group and partnership board meetings.

The family and healthy lifestyles business unit had multi-agency guidance for staff on multi-agency risk assessment conferences (MARAC). The purpose of MARAC was to provide a consistent approach to risk assessments which identified those people who were at most risk of serious harm from domestic abuse. Once a person had been assessed at this level of risk a multi-agency meeting would be held and agencies worked together to find a way of reducing and/or managing the risk using available interventions. There was also a referral pathway for staff to use to refer into MARAC following appropriate assessments. Staff told us they felt confident to use the DASH risk assessment and refer to MARAC when it was needed.

Good

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

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

Compassionate care

As part of our inspection we observed care in patient's homes, clinic settings and observed staff speaking to clients on the telephone. In order to gain an understanding of people's experiences of care we talked to 25 people who used services in the family and healthy lifestyles business unit. Staff told us they were passionate about delivering high quality patient centred care. The majority of people we spoke with were happy with the care they had received.

We received 43 comment cards largely from parents who accessed services in the family and healthy lifestyles business unit. We received very positive comments about the quality of service and care received from all these parents. We did not receive any negative comments from the comment cards.

Dignity and respect

Throughout our inspection we found members of staff treated children, young people and families with dignity and respect. Parents told us they felt respected, well supported and that staff were always polite and helpful with any concerns they may have.

For example we saw on one home visit with a health visitor to a family where there were safeguarding concerns how the health visitor treated the family with dignity and respect and was diplomatic and sensitive to the situation.

Patient understanding and involvement

Most of the parents we spoke with and the comment cards we received all indicated how involved and supported they felt by staff within the services. We observed staff within health visiting explaining care and offering support and guidance to parents. Staff also encouraged parents to contact the service in between contacts if they needed any additional support. Staff told us they treated people as individuals and would tailor care to what the individual needed.

We spoke with one parent whose child used all the therapy services. They told us the physiotherapist was their key worker and had provided a written therapy programme and co-ordinated care and feedback with the other therapists. However other parents we spoke with within therapy services had mixed views on how involved they had been in their child's care. Some parents felt they had not been involved as much as they could be. One parent told us "we currently don't have a physiotherapist so we are waiting without communication to find out what happens next."

The results of a health visitor survey in the South East quadrant demonstrated that 77% of people who returned the survey felt they had been involved in decisions about the way in which health visiting services were provided to their child and family.

Emotional support

All staff we spoke with were child and family focused and offered support to help children and parents cope with their care and treatment. Within health visiting services staff assessed mothers for signs of postnatal depression and offered support to the mother if this was needed.

Within school nursing draft guidelines had been developed to support the school nurse in the management of children and young people who self-harm, in the management of children and young people who were suffering from depression and in the management of children and young people with eating disorders. For example in the management of depression guidelines if the young person was assessed as low risk the school nurse would offer further contacts to support them with their mood/ stress or anxiety. If the young person was assessed as high risk there was guidance to say this young person should be referred to CAMHS for more targeted interventions.

Promotion of self-care

When possible, children and their families were supported to manage their own treatment and care needs. For example, the school nursing team used a website so children, young people and parents could read about bed-wetting and the different options to manage this. Staff also provided support when children and their families were referred to the enuresis service.

Requires Improvement

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

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

Service planning and delivery to meet the needs of different people

The school nursing service ran an enuresis clinic for night-time bed-wetting however staff told us there wasn't a service for children and young people who had urinary wetting in the daytime or faecal continence concerns. Senior managers we spoke with were aware of this and indicated that a day service was not commissioned. The trust provided us with information about the other services available. School nurses would give general advice and support regarding toilet training programmes for children with delayed development/special needs and refer the child or young person to their GP as necessary.

For the new academic year the school nursing service had just appointed a lead to work with education to support children and young people who were not currently in education, employment or training (NEET). Staff told us they currently did not have a system in place to identify children who were not in education for example being home schooled. The purpose of the lead role was to address this however there was no timescale for when this would be achieved. This meant the service could not currently offer the healthy child programme to children who were not in education, employment or training.

The vulnerable children and young people team undertook health assessment reviews for looked after children and young people 10 years and over particularly those who had refused their health assessment. They offered a flexible approach to health assessments, in a location that suited each child. The team worked with other services and agencies in a multi-agency way to respond to looked after children who had run away or had gone missing and with young people placed in independent residential children's homes who have been subject to /or at risk of child sexual exploitation. The team were just about to recruit a practitioner to support young people who were leaving care.

The family and healthy lifestyles business unit had just recruited a Family Nurse Partnership (FNP) team. The FNP programme is a voluntary home visiting programme for first time young mums and dads, aged 19 or under. A specially trained family nurse visits the young mum regularly, from early in pregnancy until the child was two. The Family Nurse Partnership programme was underpinned by an internationally recognised robust evidence base, which demonstrated it can improve health, social and educational outcomes in the short, medium and long term. At the time of inspection the team had recruited three clients and could take a maximum of 100.

Access to the right care at the right time

Staff within all therapy services were meeting the 18 week referral to treatment times. However staff told us on occasions patients had to wait longer periods to be seen at a follow-up appointment than had been planned. They also told us they had raised this with the general manger and they were going to meet to look at targets to improve this.

Within dental services a new waiting list initiative had been developed to help clear the backlog, set up a central booking system and establish a new referral system.

Staff in health visiting reported they had previously offered an out of hour's clinic on a Saturday morning but currently were unable to do this due to staff capacity issues. We were also told there were teams piloting an appointment led baby clinic as parents had raised concerns about prolonged waiting times in clinic.

Within the school nursing academic timetable there was a minimum offer of one drop in session per secondary school every half term. Staff told us they tried to offer as many drop-in's as they could within the capacity of the team. In one team for example they offered drop-in's every fortnight in one school as it was so popular two members of staff had been allocated to support this. The school nurses had an agreement that young people may return late to lessons as they were waiting for the school nurse. We asked due to popularity had the team thought about increasing the frequency of clinic. Staff told us they were unable to do this as they did not have capacity within the team.

Staff in school nursing particularly raised concerns about how responsive they could be meet the needs of children and young people as staffing capacity did not allow them to be as flexible as they needed to be. At the time of

Requires Improvement

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

inspection there were no waiting lists for access to services with the exception of the Lincoln area where there was a 12 week wait for children or young people to receive individual packages of care.

Discharge, referral and transition arrangements

Within therapy services there was a transition pathway to hand the young person's care over to adult services, for example in speech therapy this could include either an action plan or a visit to the adult placement to co-ordinate the transition.

As a result of a complaint the health visiting service had implemented a transition handover between midwifery services and health visiting. Staff told us this pathway had recently been introduced and it still needed to be embedded in practice but so far there had been an improvement in communication.

We reviewed information which detailed the handover arrangements between health visitors and school nurses. Where children had additional needs (on universal plus or universal partnership plus of the HCP) a face to face handover between staff was arranged. Children on the universal part of the HCP their electronic record was shared from the health visitor to the school nurse so the school nurse was aware of the child's health history.

Complaints handling (for this service) and learning from feedback

The services within the family and healthy lifestyles business unit followed the trust's NHS complaints processes. There were complaints leaflets available within the health centres we visited**.** Staff told us they knew how to manage complaints locally and how to escalate where appropriate.

Lessons learnt from complaints were discussed at the trust's safeguarding governance group. Staff were able to give examples of how they had learnt from complaints. For example following complaints about the national childhood measurement programme (NCMP) letter about a child's height and weight the trust had changed the wording in the letter and this in turn had reduced the number of complaints.

Information within the division's clinical governance and scrutiny group in August 2014 outlined an incident that had occurred which resulted in a complaint which may not have happened if tasks and notifications had been reviewed in a timely manner. Following this, teams within children's services had an allocated member of staff to deal with tasks in a daily basis. For example if a child attended the out of doctors this would be sent as a task to the relevant children's and young people's team so any actions the team needed to take could be completed in a timely manner.

Requires Improvement

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

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

Vision and strategy for this service

We spoke with the general manager and head of clinical service who told us there was work in progress between all partner agencies and across the health community to work on the vision and strategy for children and young people's services across Lincolnshire. This was due to be completed by in the next few years. However when we spoke with senior managers and staff it was not clear what the trust's current vision was for children's services.

Health visiting services were on trajectory to ensure the local population's needs were met in line with the health visitor implementation plan which was monitored by NHS England. Staff demonstrated some awareness of the health visitor implementation plan and its aim to expand and develop the service but were unable to articulate how the service were implementing this and when this would be achieved by. The general manager told us there had been internal and external engagement events which staff had attended about the health visitor implementation plan.

During our inspection we found there was confusion over the number of health visitors actually having face to face contact with children and there were large differences between the caseload numbers health visitors were working with. We asked senior managers about this who confirmed staff had not been deployed in the 'right places' across the health visiting service. The general manager and head of clinical services told us they were aware this was something they needed to address but were unable to show us firm plans of when and how they would address this across the trust. Senior managers told us they anticipated they would fully implement the Healthy Child Programme when they had met their target staff numbers.

Within therapy services, staff told us there was not an overall vision for the service and there wasn't a therapist lead at a senior level for the service. At one of the focus groups staff told us they had raised this with the general manager who had agreed to look at this.

Guidance, risk management and quality measurement

The family and healthy lifestyles division had a scrutiny group which reviewed quality and safety within the division. Agenda items included incident reporting, complaints and policy and procedures. In the meeting minutes from May 2014 services within the family and healthy lifestyles business unit had developed a patient information leaflet to advise parents on the dangers if their child ingested the liquid from e-cigarettes. This was a result of an incident where a child had been admitted to hospital following ingestion of the liquid. This showed the services learnt from incidents and tried to raise awareness of health issues for people who used services.

In minutes from the quality and risk committee there were standing agenda items which included themes and trends of complaints and serious incident reports. For example in minutes from February 2014 under lessons learnt the outcomes of a RCA into non-accidental injuries to a baby were discussed.

Within the quality and risk committee minutes assurance were given using a RAG rating system. The ratings were explained in the minutes so it was clear what the rating meant. For example we saw an amber rating meant effective controls were thought to be in place but assurances were uncertain and/ or possibly insufficient. We saw in the minutes of the 19th June 2014 quality and risk an amber rating had been given to a number of overdue incidents across the trust. This meant the trust had mechanisms in place to identify risks to quality and safety within services in the family and healthy lifestyles business unit.

The family and healthy lifestyles business unit had developed an action plan following the review of Health Services for Children Looked After and Safeguarding in Lincolnshire in 2013. The majority of the actions had been completed but there was some further actions required in relation to paediatric liaison enabling risks to children to be effectively identified and followed up on and liaison between health visitors and GP practices which a link role had been established.

Leadership of this service

Staff reported they received good support from their direct line managers and spoke positively about the leadership from the general manager. All staff stated they felt the

Requires Improvement

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

general manager was approachable, listened and acted upon what they said. New line management arrangements had recently been put in place within health visiting and school nursing services.

Staff across the family and healthy lifestyle division stated they had met the chief executive through "back to floor" visits and felt the board were visible within the trust.

Culture within this service

We found there was a culture of openness among all the staff and teams we met. Staff spoke positively about the services they provided to children and young people. We observed staff working well together and there were positive relationships with other multi-agency partners such as children's centres and schools.

Public and staff engagement

There was an overall trust strategy for patient and public involvement 2014-2017. Results from a patient satisfaction survey within health visiting services for the south east quadrant June 2014. One of the recommendations from the survey was to look at the setup of child health clinics to support privacy and dignity. Staff in one health visiting team told us how they now used a different room and saw parents and children one at a time. Staff in another health visiting team told us they had consulted with parents about their child health clinic. The clinic had been a drop in service and parents were found to be waiting for long periods of time. A new pilot appointment clinic had been introduced and feedback had been positive.

There was a patient survey currently being undertaken within school nursing services and the first report was due at the end of September 2014. The school nursing service and therapy services were also due to be involved with the trust's 'iwantgreatcare' survey which was also starting in September.

During our inspection staff told us about a formal consultation process which had been started to move staff permanently to the Boston team. We spoke with senior managers about this who told us they had asked staff to volunteer to move bases but no volunteers had been found. The outcome of the consultation was that six staff were to be permanently redeployed to the Boston team however and it was not clear from the information the timescale when staff would be moved into the team and we saw the risk had been identified in April/ May 2014.

Innovation, improvement and sustainability

The health visiting had developed a breastfeeding website so parents were able to access support and guidance 24 hours a day seven days a week. This had been launched during breastfeeding week in August 2014. We saw leaflets which advertised the website and these were given out to parents.

The school nursing service had undertaken safeguarding pilot to support school nursing services in managing the health needs of vulnerable children and young people. The pilot involved the development of a robust evidence based process with pathways. The aim of this was to ensure school nurses were involved with the children and young people where they could make a difference rather than being part of the safeguarding process for every child even if they had no health needs.