Northern Lincolnshire and Goole NHS Foundation Trust

RJL

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

This report describes our judgement of the quality of care provided within this core service by Northern Lincolnshire and Goole NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

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

Summary of findings

Ratings

Overall rating for the service	Good 
Are services safe?	Good 

Summary of findings

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Summary of findings

Overall summary

Northern Lincolnshire and Goole NHS Foundation Trust provided services to children and young people up to the age of 19 across North Lincolnshire. The organisation provided a range of services including the family nurse partnership, health visiting, community children's nursing, looked after children's team and paediatric therapy services. These services were provided in people's home, schools, clinics and children's centres throughout the local area.

Children and young people under the age of 20 made up 23.2% of the population in North Lincolnshire and 11.2% of school children were from a minority ethnic group. The health and well-being of children in North Lincolnshire was mixed when compared with the England average. Infant and child mortality rates were similar to the England average. The level of child poverty was worse than the England average with 19.8% of children under the age of 16 living in poverty. The rate of family homelessness is better than the England average. Childhood obesity levels are in line with the England average; 9.7% of children aged 4-5 years and 20.7% of children aged 10-11 years.

We visited eight locations across the Northern Lincolnshire area. We attended two baby clinics, health visitor bases, children's therapy bases, the child development centre, and the looked after children's team, a monthly health visiting team meeting and with parents' permission, went on three home visits.

We spoke with 46 members of staff, including senior managers and team leaders, health visitors, therapists, specialist nurses, administration and support staff. We did not inspect the school nursing service, as this was not provided by the trust.

Therapy services had moved to electronic records. We were shown how information was inputted and stored on the system and reviewed two electronic records for therapy services and ten records for health visiting.

Summary of findings

What people who use the provider say

Families we spoke with during the inspection were positive about the care they received.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should continue to embed the acuity tool to provide equity of caseloads across the health visiting teams.
- The trust should review compliance with the National Health Visiting Service Specification (March 2014)to ensure all staff have access to sharing information to safeguard or protect children.

Northern Lincolnshire and Goole NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

During our previous inspection in October 2015, we rated safe as requires improvement because:

- There was no safeguarding supervision policy in place in line with national guidance.
- Staff we spoke with did not know the process and tools used to allocate caseloads to the health visiting teams.
- There was no designated doctor for looked after children.
- We had concerns that incidents were not shared across the service.

During this inspection we rated this service as good because:

- We found that learning from incidents was shared across the service and that incidents were a standing agenda at monthly meetings.
- We saw that a new acuity tool to assist with caseload weighting had been recently passed by the governance committee and was starting to be used however this was still being embedded at the time of our inspection.
- We saw that a designated doctor for looked after children was now in post.

However we also found:

- Health visiting caseloads remained higher than the national guidance (below 300) and it was unclear if the new acuity tool would address this.

Good

Are services safe?

- Children's therapy services had high caseloads. However, this was on the community risk register and actions had been taken to mitigate potential delays in children being treated.
- Families in North Lincolnshire were not on the same electronic record system as the Family Nurse partnership (FNP), therefore records were not transferable. This did not adhere to the National Health Visiting Service Specification March 2014, which states 'providers will ensure that all staff have access to sharing information to safeguard or protect children'.

Detailed findings

Safety performance

- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There had been no never events within community children's and young person's services.
- Data from the patient safety thermometer showed that the trust reported no pressure ulcers, no falls with harm, venous thromboembolisms (VTE's) and no catheter urinary tract infections between August 2015 and August 2016 in children's community services. The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and urine infections to be measured on a monthly basis.

Incident reporting, learning and improvement

- Electronic systems were in place for reporting incidents. Staff we spoke with, in all the services we visited, were able to explain the process for reporting incidents. Staff also said that feedback from incidents had improved across the teams.
- Staff told us that they felt confident to report incidents without fear of recriminations and that they had felt more informed about incidents.
- There were now additional processes via the electronic reporting system to ensure managers feed back the progress of the incident reported, to the referrer.
- Between October 2015 and October 2016 there had been 43 incidents within community children's services. One of these was categorised as low harm and the rest were no harm.
- Five of these related to poor communication from out of area midwifery services to health visitors and had been addressed with the individual departments. 15 incidents related to child health departments from other areas who had not notified the trust's child health department about a child. This had created delays in the completion of new birth visits. There had been three occasions when midwives within the trust had not referred women to health visitors in line with the trust's guidelines. These had been addressed and we were told that the referral pathway would be electronic in the near future. Other incidents related to other agencies and the need to escalate concerns about a child's welfare with the support of managers and the trust safeguarding children team.
- We were told feedback from incidents was also available on the 'hub' on the trust intranet but staff told us these were usually hospital-based incidents.
- We looked at the minutes of three of the monthly governance meetings attended by managers and saw that incidents were discussed at these meetings. A 'lessons learned' newsletter was also used to cascade learning from incidents.
- We reviewed minutes of several meetings from different staff groups including therapists, health visitors and the whole team meetings and were assured that learning and feedback from incidents was consistent across all the teams.
- We were told and observed that information from incidents was fed back at team meetings. We saw this at a health visiting team meeting we attended. We also saw evidence of this in the minutes of two previous meetings.
- We saw that the wider trust agenda had a priority of learning from incidents that was evident in children and young people's services. Staff told us that they felt more informed of incidents across the trust and received weekly bulletins via e-mail.

Good

Are services safe?

- Staff we spoke with demonstrated an understanding of the Duty of Candour requirements. There had been no recent incidents that had required the duty to be implemented in this service.

Safeguarding

- The organisation had policies and procedures in place for safeguarding and staff could describe how safeguarding referrals were made and gave us examples of when they had done this.
- Staff knew who to contact for advice and told us they would speak to the children's safeguarding team or their line manager.
- We also looked at flow charts which clearly directed all community staff if they had a safeguarding concern. These included contact numbers for external agencies such as social care and the police.
- Trust-wide figures for children's safeguarding training were 90% in July 2016; this was lower than the trust target of 95%. We saw evidence on site that the health visiting and nursery nurse staff were above the 95% target.
- A 'flagging' system was used on the electronic record to identify any children with safeguarding alerts. The electronic records we saw, evidenced safeguarding policies being followed and liaison with other agencies such as social services.
- Staff from the family nurse partnership (FNP) team had all completed level three safeguarding training and level four accredited training.
- The National Health Visiting Service Specification 2014/ 2015, which was published in March 2014, states that health visitors must receive a minimum of three-monthly safeguarding supervision of their work with the most vulnerable children and babies on their caseload. A colleague with expert knowledge must undertake with this. At the time of our previous inspection, this had been taking place six-monthly and it was a subsequent recommendation that the trust must adhere to the specifications.
- At this inspection, we saw that there was now a well-embedded safeguarding children supervision policy and that 100% of eligible staff had accessed three-monthly supervision as outlined. Staff showed us this policy on the intranet and were positive about the benefits. Staff had six monthly safeguarding supervision from a member of the trust's children's safeguarding team and from peers with supervision competencies, in between. Staff within the FNP had a system of monthly safeguarding supervision in place.
- Staff told us information relating to safeguarding was easily accessible and we were shown folders where this information was stored on the intranet and contact details for other agencies.
- The safeguarding team were accessible and staff were able to provide examples of when they had contacted them for advice. These included support for referring to external agencies when there were professional differences of opinion regarding thresholds for potential harm.
- The Looked after Children's (LAC) team had an office next door to the safeguarding team so had a close working relationship. They told us that a weekly notifications list was produced and about other systems in place to track and trace LAC. There were clear inter-agency processes in place if children went missing.
- Staff knew of their roles and responsibilities in serious case reviews where a child has died or suffered significant harm as defined in 'Working Together 2015. Staff could also tell us about their role in the child death overview process which is a national programme to understand why a child or young person has died.
- Child sexual exploitation and female genital mutilation (FGM) were also explored in relation to policies and procedures in the safeguarding supervision policy.
- We were told that there had been a significant increase in families where early help intervention was needed and this had been difficult in relation to staff capacity. We saw that this was an agenda item on the monthly health visitors meeting and that the management team were working with social care managers to address this.
- Staff told us FGM was covered within their safeguarding training and there was a pathway for staff to follow. We reviewed the policy which gave clear definitions and reporting procedures as defined by national legislation

Good

Are services safe?

(National Police Chief Constable's Council 2015) .There had been no known notifications in the area but staff were aware that current changes to population groups could result in future identification.

- Staff told us that sometimes there were communication difficulties due to staff in other areas not having access to the same electronic systems. This could have implications if there were safeguarding concerns.
- The trust was developing an electronic referral system from midwifery to health visiting to mitigate the risk of paper referrals being lost. Staff told us if they had concerns, they would speak directly to other teams by telephone or face to face.

Medicines

- All health visitors and members of the FNP were independent non-medical prescribers. All of these staff had received the appropriate training and updates from the local university. This enabled timely access to medicines and treatment.
- We saw that prescription pads were stored securely. There was a clear process for staff to order new prescription pads which included recording of the serial numbers for traceability.
- Staff we spoke with said that the pharmacy department within the hospital could be contacted for support if required.

Environment and equipment

- We checked equipment for evidence of electrical safety testing and maintenance. This was up to date on all the equipment we checked in all the areas we visited.
- Therapy staff told us the process for borrowing equipment from the equipment store and the process of applying through the monthly panel meetings for other equipment. Occupational therapy and physiotherapy staff told us that equipment requests for children were usually approved, and when it needed replacing, for example as the child grows, further panel approval was not required.
- Health visitors each had a set of scales which they took on home visits and used in baby clinics. We saw evidence of weighing scales and carbon monoxide analysers being calibrated and dates for review put on equipment.
- We saw that baby monitors, used in the care of the next infant scheme to reassure to families who had a family history of sudden infant death syndrome, had been maintained by the medical engineering department.
- We reviewed the community equipment service protocols for maintaining equipment. From speaking with therapy staff, we were assured that systems were in place to maintain equipment once in schools or people's homes.
- We visited a number of locations where teams were based and clinics were held. They were all well maintained and suitable environments for families and children.
- The premises for the Child Development Centre (CDC) had been refurbished since our previous inspection and we saw this was appropriate for childrens' care.

Quality of records

- We reviewed twelve sets of records from community children's services. This included two from therapy services and found they were detailed and fully completed allowing for traceability. They included clear plans about interventions. We saw that these included appropriate information from external agencies such as social care.
- We saw that records included up to date information about groups and relationships to understand the family dynamics. This had been added to the records as a result of national learning from serious case reviews.
- We were told records were peer reviewed and we saw monthly audits and the outcomes were shared at professional meetings to identify any gaps or areas for improvement. We attended a health visiting team meeting during our inspection and saw that this was a standing agenda item.
- We saw clear systems for the transfer of records if a family moved area. This included a system for travelling families who did not stay in the area all year. This ensured that information followed the child as required, but was also held for their return. There were clear processes for transferring records if a child was subject to a child protection plan or had become looked after by the local authority.

Good

Are services safe?

- A nationally recognised electronic records system was used for record keeping. Some external documents such as social care assessments had to be scanned into the system, as there was no facility to input directly in to the electronic system. Staff told us they felt electronic recording had taken time to become embedded however; those we spoke with, told us they now felt it provided a safer record keeping method. Other professionals using the system were able to allocate tasks to individuals which meant any interventions or treatments needed were identified to the appropriate professional in a timely manner. For example, staff could refer to, or receive information from, the paediatric liaison nurse within the acute hospital setting.
- Some areas had champions for the electronic records system and dedicated time had been given to a health visitor with an interest in information technology to try and improve systems and processes. We saw that this health visitor had been proactive in completing record keeping audits and highlighted areas for action, in particular the collection of family information about religion and culture. This work was being implemented across the service. This health visitor had recently been given an award for her work in this area.
- The family nurse partnership (FNP) covered North Lincolnshire and Goole. Families in the Goole area had generic electronic records. This meant that universal health visiting teams could access the records. Families in North Lincolnshire were not on the same electronic record system as the FNP, therefore records were not transferable. This situation had been escalated, but was not seen to be a concern so no further action had been taken. This did not adhere to the National Health Visiting Service Specification March 2014, which states 'providers will ensure that all staff have access to sharing information to safeguard or protect children'.
- The LAC team could access the electronic records to look at children's attendances to the Accident and Emergency department, children's immunisation status and inpatient hospital records if needed. This meant if they had concerns they could access further information relating to a child.
- We observed home visits being recorded electronically at the time of the visit. We saw that staff involved the child's carer, who was shown the record and given an explanation about what the health visitor had written. Some health visitors told us they did not like using a lap top in the family home as they felt it was a barrier to communication.
- We saw that child health records were held by parents in a 'red book'. These had been updated to include up to date information from national and local guidelines including safe sleeping.
- We saw information was recorded in parents' 'red books' during baby clinics; however, during the two baby clinics we visited we noted that information was not recorded in the electronic system at the time of the consultation. Information was written on a clinic attendance sheet, this was then added to the records following clinic. A concern from our previous inspection in 2015 had been addressed. This related to records being printed from the electronic system for a multi-disciplinary team meeting then collected for shredding at the end of the meeting. We were assured that this practice no longer took place.
- Staff using laptops could access electronic records remotely. These could only be accessed by use of a smart card. We were informed that connectivity was an issue in some areas and that this had led to difficulties in sharing information and completing reports. This had been on the risk register since October 2015 and there had been work to try to improve connectivity. This had been due to be reviewed in October 2016, however we did not see an action plan to address this. The electronic records system was a standing item on all of the meeting minutes we reviewed.

Cleanliness, infection control and hygiene

- The trust had policies and procedures for infection prevention and control (IPC). Staff we spoke with told us that these could be accessed on the trust intranet.
- IPC training was part of annual mandatory training for staff. The trust target for mandatory training was 95%. IPC training compliance for community services was 91%. This data was for all community staff not specifically those employed within children's services.

Good

Are services safe?

- The children's centres, clinics and health visitor bases we visited were all visibly clean. Hand washing facilities, alcohol gel and personal protective equipment was available. Toys were made of plastic and we saw that these were cleaned at the end of a baby clinic.
- We observed staff using alcohol gel to clean their hands between patients and that staff were 'bare below the elbows'.
- In baby clinics, we saw that equipment was cleaned with wipes between each patient.
- We reviewed ten department infection control review tools, which included hand hygiene facilities. They were from a range of areas including children's centres and health visitor bases. Each scored between 80% and 100% for hand hygiene facilities being available. A direct observation of hand hygiene was not included in the tool; however, an annual hand hygiene competency audit was completed with action plans developed if compliance was less than 100%. This data was collated within a red, amber, green (RAG) rated dashboard which we reviewed.

Mandatory training

- Staff told us that a training matrix was used to inform them when training was due. We were also told a more co-ordinated approach to mandatory training had been taken to try and have a training day to complete all training rather than several separate sessions. This had been facilitated by an educational lead.
- The staff we spoke with, said they were up to date with their mandatory training and the changes discussed above had had a positive impact. This was reflected in the mandatory training levels we reviewed which were between 93% and 99% for staff within community children's and young people's services.

Assessing and responding to patient risk

- Staff told us that risk assessment was part of their role and was included in their standard documentation used on the electronic system.All records we reviewed showed that risk assessments were completed and shared appropriately.
- There were pathways in place for staff to follow in response to potential risks, for example if parents failed to attend for an appointment or if children were not present at home visits.
- We reviewed the pathway for perinatal mental health and saw that the clarity of timescales had been improved.
- We saw that pathways were available to support staff if a child's health deteriorated, for example if the child suffered significant weight loss, failed to meet or had a deterioration of, developmental milestones.
- Staff told us about situations where they would not be happy to conduct home visits alone. This information was stored electronically so it would alert any other staff to ensure they were accompanied. Staff told us that they would ensure other professionals were aware who might not be on the same electronic system for example general practitioners (GPs).
- A designated doctor for LAC had recently been appointed. This meant that this vulnerable group of young people received statutory health assessments and care.
- Health visitors asked about domestic abuse as part of their routine enquires and were skilled in identification, reporting and being involved in the multi-agency risk assessment committee processes.

Staffing levels and caseload

- We reviewed caseload data for therapy staff (physiotherapy, occupational therapy and speech and language therapy). We found that caseload numbers varied from two to 114. There were 1.6 whole time equivalent (wte) physiotherapists in post to cover the geographical area. We were told that the current caseload was approximately 180 children. This was on the risk register as a moderate risk. A business case to increase the establishment had been unsuccessful.
- An action to develop joint pathways to work more efficiently was recommended. We saw actions which included occupational therapy adult workers with children's competencies supporting caseloads. A triage system had also been developed so that the children

with the highest need were prioritised. By having a very clear pathway and staff working more flexibly, children's therapies had reduced to a one to four week wait from 18 weeks.

- To address recruitment, there were moves to 'grow own staff' in the long term and the trust had developed links with universities and colleges.
- Speech and language therapists were also a moderate risk on the community risk register as there was a reduction in staffing due to recruitment issues. This was a risk as there was potential for the service to be reduced. A locum therapist was currently in place to mitigate this.
- There had been a significant reduction in paediatric dietitians from 4.8 wte to 3.0 wte which could result in potential breaches of four week waiting times. There was no evidence, to date, that this occurred. This was also identified on the community risk register. This was a service where it was not always appropriate to provide cross cover from adult services. Dietitian assistants had filled some gaps in routine work and locums were being considered.
- Lord Laming's report (2009) on the protection of children in England stated that health visitor caseloads should be no more than 300 children. The management team told us that caseloads for each visitor were between 300 and 350 children. This meant that the recommendations were not achieved.
- During our inspection in 2015, we were not assured that an acuity tool was being used to look at caseload weighting. However, it had been recognised that in certain geographical areas, in particular those with higher levels of deprivation, health visitors had higher caseloads.
- During this inspection, we saw that an acuity tool had recently been implemented. It was envisaged that this tool would assist in addressing some of these issues as it provided a more equitable way of weighting caseloads. This would enable managers to compare caseloads and move staff accordingly.
- We were told that weekly management meetings also took place to review the acuity of caseloads. This was due to the recognised variations of acuity within caseloads. In particular, those caseloads where children were subject to early help pathways, child protection plans and family court processes were flagged.
- Staff told us caseload allocation was a challenge due to the large geographical area and the differences in levels of deprivation; however, this information was now helping to determine caseload allocation.
- Information provided by the trust showed that the percentage turnover of staff within health visiting varied from team to team and was between 0% and 29.6%. We were told by managers that this was linked to retirement within some of the teams. We were told that several health visitors would retire in 2017 however, some planned to come back part-time. There was some uncertainty about how this would affect services.
- The 0-19 years proposed service model would mean a review of staff and the financial implications were not yet known.
- The FNP was led by one wte supervisor and had three wte family nurses in North Lincolnshire. The team also had a Quality Support Officer. We were told their current caseload was in line with the national recommendation of 25. However, the service was due to be de-commissioned and there was a plan in place for these families to be supported by health visitors.

Managing anticipated risks

- The organisation had a lone worker policy and staff were provided with lone worker devices. Staff we spoke with, were aware of the policy and showed the inspection team their lone worker devices. We observed the lone worker procedures being followed on the home visits we attended.
- Staff also ensured that their electronic diaries were updated so that colleagues knew where they were. Staff had also recently been given alarms which alerted management and police to concerns if a member of staff felt at risk. The use of these was put on the community risk register whilst their use was being embedded.
- The LAC team were unaware of the new alarms, but did visit young people within foster care and residential units out of hours.

Good

Are services safe?

- Staff told us that they could access alternative venues if it was deemed unsafe to perform a home visit following risk assessment.

Major incident awareness and training

- Staff told us during adverse weather conditions they would prioritise their workload, or may work from home and contact families by telephone if it was deemed too dangerous to travel.
- The trust had contingency plans in place. A recent information technology system issue had been managed appropriately.