

Lancashire Care NHS Foundation Trust

RW5

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW5HQ	Sceptre Point		PR5 6AW
RW5CV	St Peters Primary Healthcare Centre		BB11 2DL




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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

The service faced a number of challenges including staffing levels in some teams; large case loads, the fluctuating population from seasonal workers and students and the increased acuity of patients. The needs of children in the community had increased, as there were no other services to assist them.

Clinics were scheduled weekly at set times with some open and some pre-booked slots. With a lack of national guidelines for waiting times, the trust had set a preliminary nominal target of 18 weeks. Data supplied by the trust showed waiting times varied in each speciality. Overall, from April 2014 to March 2015, the average percentage of referrals waiting over 18 weeks for all services had decreased from 10% to 3% and the referral waiting the longest time reduced from 22 weeks to 16 weeks. Waiting times for patients once they had been accepted in a team were short.

Many services were being delivered from less than ideal locations that were not owned by the trust. The low number of risk assessments for clinic locations and the fact that they were not complete or comprehensive meant the potential risks were not being clearly identified or addressed.

Electronic patient records were not always accessible when connectivity was poor and access to paper based records was variable throughout all areas. Electronic templates had not been set up for all the specialities, which meant staff continued to maintain paper records, which could not be accessed across other specialities. Issues were raised in relation to “Red Books” which were not always fully completed with names and address of the children and the “Flimsy’s” in the red books were inconsistently completed and we saw evidence of poor quality of scanning of these ‘flimsy’s’ making them illegible.

Medicines were managed safely in most cases but at a school vaccination session, we observed the temperature of vaccine storage was allowed to go over the recommended range potentially affecting the cold chain storage making them unfit for use.

The trust target to achieve 90% uptake by 31 August 2015 was not yet met as the actual uptake ranged from 59% to 73% at the time of inspection with four months

remaining. The vaccination and immunisation team target at 90% was not met due to a considerable amount of unreturned consent forms and low take up rates within Muslim communities declining the vaccination that contained porcine gelatine.

The vaccination and immunisation team were not always following the trust’s consent policy in relation to the Gillick competency and Fraser guidelines, which resulted in some children not being vaccinated or the parents being contacted to gain verbal consent. Young people only had a gown to protect their modesty and female students were asked if there was any chance of pregnancy in the open hall without due consideration to their privacy.

There was no routine antenatal contact by the health visiting team where breastfeeding support and advice should be given. The routine health visitor contact became part of the health visitor contract in April 2014, however, it had been agreed with commissioners that this would be introduced on an incremental scale starting with those deemed most vulnerable (ie highlighted by Children’s Centres and Midwives). It became routine in September 2014, again with the expectation that the number contacted would increase each quarter.

The coordination of Children Looked After (CLA) who were under the care of the local authority (Lancashire County Council) was a challenge especially when the child was placed out of Lancashire’s boundaries as the LCFT CLA nursing teams had to coordinate the referral, discharge and transition of the child with social services teams from all over the country to perform assessments.

Discrepancies between data held at trust and local levels regarding the uptake of mandatory training meant we could not evidence that the target of 85% attendance for mandatory training was being consistently met within the service. Data from the trust’s centralised mandatory training system showed basic life support training being at 64% at the time of the inspection. Overall compliance was 83.9% at January 2015. The local system showed that compliance rates for all modules were above the Trust’s target of 85% as at end of April 2015.

Trust records showed, as of March 2015, only 54% of all staff had received appraisals for the year 2014 to 2015.

Summary of findings

Care and treatment, policies and procedures and mandatory training was evidence-based and followed recognisable and approved guidelines. Pain relief was administered and applied as required through medication and via specialised equipment. We observed collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of care.

Parents, carers and children were positive about the care and treatment provided. The NHS Friends and Family Test results showed the majority of patients would recommend the department to their family and friends. Patients felt they were afforded sufficient privacy and dignity.

Staff were compassionate, kind and respectful whilst delivering care. We observed positive interactions between staff, patients and their relatives when seeking verbal consent.

Staff clearly expressed the trust's vision and values and portrayed positivity and pride in the work they did. There was effective teamwork and visible leadership across the teams. There was a positive attitude and culture within children's services with an ethos on all the services working together with best practice coming from the whole group rather than any individual.

Public and staff engagement was embedded and included initiatives such as a partnership with Hyndburn Council and Public Health Lancashire in the launch of a voluntary ban to encourage people not to smoke in Council Play Areas and working with people from the community to conduct research studies about how cultural beliefs had prevented access to healthcare. The Early Start Team felt proud and honoured to have their hard work and efforts recognised with a National Nursing Times Award.

Summary of findings

Background to the service

Lancashire Care NHS Foundation Trust provided community health services in the Lancashire area for children, young people and families. Services included health visiting, school nursing (including special school

nursing), speech and language, occupational and physiotherapy, among others. Services were provided in clinic settings, as drop-in sessions and a large number of children and families were seen in their own home.

Our inspection team

The team for community health services for children, young people and families included two CQC inspectors, a paediatric nurse, a health visitor, a school nurse and an expert by experience in the field of working with children and younger adults.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 28 to 30 April 2015.

We spoke with a large number of staff including the children and families network director and the clinical director, as well as their deputies.

We spoke with the service line clinical leads for the Children's Integrated Therapy and Nursing Service (CITNs) and universal services

We also spoke with the professional lead for public health nursing and the team coordinators for West Lancashire (CITNs); Preston West child and family health service and for CaSH Services (Central).

Others included the named nurse for children looked after (CLA), an information specialist, the performance manager, staff nurses, a deputy team leader and clerical officers in the vaccination and immunisation team,

school nurses, occupational therapists, speech and language therapists, a specialist nurse for children with complex needs, health care assistants, health visitors, student nurses, nursery nurses and clinical psychologists.

We visited clinics in different areas of Lancashire. These included the Whitegate Health Centre (child psychology service); Leyland House (executive interviews); Holly House (Child Development Centre); Cottam Lane Surgery (baby clinic); Clayton brook children's centre – (Sure Start) Baby clinic); St Peters Centre (CaSH); , Penwortham Health Centre, Sir Tom Finney School, the Children's Integrated Therapy and Nursing Service (CITNs) and Ingol Health Centre.

We observed vaccination and immunisation clinics, school nurse drop in sessions and home visits as well as shadowing a child protection conference from the Avenham base.

During the visits, we held focus groups with eight health visitors and 11 school nurses who worked within the service. We reviewed over 40 records and spoke with over 70 children, young people, their families, relatives and

Summary of findings

representatives. We used information provided by the trust and information that we requested to inform our inspection. We also looked at paper and electronic medical records in all of the areas we visited.

What people who use the provider say

People at clinics wished that they could see more of their own health visitor. This was reflected in the friends and families test.

The majority of people interviewed were happy with the service that they received.

Areas for improvement

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

MUST

- Ensure appropriate staffing levels and caseload mix is determined to meet the needs of patients using a recognised management tool.
- Ensure the cold chain is maintained for vaccinations used and ensure monitoring for adverse reactions is undertaken and appropriate guidance followed when taking consent.
- Ensure premises are safe to use for their intended purpose.
- Ensure completion of mandatory training and personal development reviews to meet the trust targets.

- Ensure the trusts centralised system for mandatory training is accurate and up to date and reflects the local figures without discrepancies.

SHOULD take to improve

- Review records management to ensure records are managed effectively and all areas of concern are documented. Consideration should be made to minimise duplication and the risk of transcription errors.
- Ensure data regarding the completion of mandatory training and personal development reviews are robust.

Lancashire Care NHS Foundation 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 services safe?

By safe, we mean that people are protected from abuse

Medicines were not always safely managed as we saw the storage temperature was allowed to go over the recommended range at a school.

The environment was not always practicable for the clinics being conducted by staff especially where the location was not owned or managed by the trust. Immunisation clinics in schools did not always promote a calm and safe environment. Risk assessments were not in place for every clinic location, at the point of care and staff were not always aware of them. The risk assessments supplied were not comprehensive with many areas being omitted from them.

The combination of paper based and electronic records was not safe and did not allow safe sharing of information across all the teams and meant a duplication of effort with

a risk of transcription errors. Issues were raised in relation to “Red Books” which were not always fully completed with names and address of the children and the “Flimsy’s” in the red books were inconsistently completed.

Staffing levels were not met in some teams and some teams told us they were stretched at times. The two systems for recording attendance at mandatory training showed different results, therefore we could not clearly evidence that the target of 85% attendance for mandatory training was being consistently met within the service.

Safety performance

- Incidents reported to Strategic Executive Information System (STEIS) between 1 February 2014 and 31 January 2015 included 39 serious incidents and 36 deaths related to children and young people's community and mental health services..
- Between April 2013 and March 2014, 5% (586) of reported Patient Safety Incidents within the children and young people's community and mental health services were for 'Self Harm'.
- Between July 2014 and September 2014, 30 medication errors were reported in the children & families network which delivers both community and mental health services. The majority (11) were in relation to the recording of controlled drugs.
- The National Safety Thermometer is a national prevalence audit which allows organisations to establish a baseline against which they can track improvement. There had been no recorded new pressure ulcers, falls with harm or catheter and new Urinary tract infections (UTIs) in the last 13 months in community health services for children, young people and families.

Incident reporting, learning and improvement

- Incidents were raised via the electronic incident reporting system known as "Datix" with a policy to support this.
- Staff had received recent training on the incident reporting system; however, the understanding between staff around the categories of incidents to report varied. Staff described they would report serious incidents but not the less serious incidents or near misses. We found one incident which had not been reported as staff had felt it was not relevant. A young person had a reaction following a vaccination in school and had not required adrenaline but the staff had been concerned enough to have adrenaline ready in case it was required. Staff had completed a yellow card for the drug reaction. The yellow card scheme is a reporting mechanism to the Medicines and Healthcare products Regulatory Agency (MHRA) who monitor all drug reactions in the UK.
- Staff could describe recent incidents and clearly outlined actions that had been taken because of incident investigations to prevent reoccurrence.
- Learning from incidents was shared across the department via team information boards, newsletters and at handovers. We were given examples of where parents had been involved in the investigation process.

Duty of Candour

- Staff, across all disciplines, were aware of their responsibilities regarding the Duty of Candour legislation.

Safeguarding

- Executive leads and various supportive roles (safeguarding champions) worked together to promote safeguarding of children in the organisation.
- The deputy clinical director and the service line clinical lead for universal services told us safeguarding was a "Golden Thread" (an underpinning principle) present in all the work undertaken and everybody's business.
- Lancashire Care's approach was to involve and work with the whole family and not just the individual, where possible, to encourage engagement.
- Staff received quarterly supervision and questionnaires specific to safeguarding areas in their roles. They could discuss the safeguarding issues on their caseloads and be challenged on their management of the families.
- At the time of inspection, the trust's centralised mandatory training system showed staff attendance for mandatory training was 94% for safeguarding children and 84% for safeguarding adults. However, following the inspection, figures provided by the trust local system showed the compliance rate for safeguarding children of 98% and 95% for safeguarding adults.
- The safeguarding team held monthly meetings locally and chaired the safeguarding committee. The agenda included reviews of serious cases and assurance was gained of any changes to practice and the impact this had made. One example was of a child at college who had committed suicide. The review had identified correspondence had gone to the child's parents rather than the child and opportunities to engage with the child had been missed. As a result, correspondence now went to the child and their representatives.
- One challenge, staff faced across the teams, was managing the differing thresholds of reporting safeguarding concerns in line with local policy and procedures. The Local Authority social services teams had different thresholds and the responses received by staff were not always uniform.
- Electronic records included an area for any safeguarding alerts or issues to be recorded. The system flagged these up to all the professionals involved in providing care. However, we found one occasion whereby a health

visitor had not fully documented issues in relation to safeguarding on a “Flimsy” and teams still using paper-based records couldn’t always share information to other teams.

- We observed a child protection case conference where the health visitor report had not been shared with the family prior to the conference. This is not in line with the trust’s safeguarding policy. The reason given for this was due to the long-term staffing shortages and the high level of safeguarding referrals within the team.
- Staff felt the systems and processes for detecting and reporting any safeguarding concerns were safe and the organisation had a safeguarding strategy and priorities plan in place.

Medicines

- Guidance for prescribing in children and adolescents under the age of 18 years was supported by a specific procedure, approved by the drugs and therapeutics committee.
- We observed medicines management at a school vaccination session. The vaccines were transported safely, locked in a cupboard and stored in a suitable cool box at the correct temperature of between 2 to 8 Degrees Celsius (the National Patient Safety Agency recommended range).
- However, during the vaccination session the temperature was recorded at 10 degrees centigrade, which was above the national recommended limit. This change in temperature could potentially affect the cold chain storage of the vaccinations making them unfit for use. Staff stated it was a new thermometer as the usual thermometer was faulty and did not have any calibration paperwork in place. The thermometer did not alarm to notify staff of the change in temperature to an unsuitable level.
- The trust policy stated, “Recipients of any vaccine should be observed for immediate adverse drug reactions. As there is no evidence to suggest a specific length of time for observation post immunisation, the immunisation nurse will determine whether the child is unfit to return to class”. We observed that young people were sent back to their lessons immediately after the vaccination was given with no assessment of whether the child was unfit and no period of observation for any adverse reactions.

Environment and equipment

- Requests for the purchase of equipment were presented and approved at a panel held fortnightly. This included professionals such as physiotherapists and occupational therapists.
- Any urgent requests, such as equipment for children with complex needs, could be discussed with appropriate professionals and approved outside the panel.
- The majority of equipment for children, especially those with complex needs, was tailor made at the point of ordering which caused some delays between the order being placed and the delivery date.
- Due to the bespoke nature of the equipment, a large quantity of items was not held in stock.
- Staff worked with manufacturers, representatives and with neighbouring trust to ascertain the most appropriate items to purchase making it a multi-agency approach.
- Staff reported no issues or complaints around equipment being available. Systems for tracking medical devices/equipment given to patients were in place; however, staff felt these were not always efficient because they could not always locate all the equipment.
- There was appropriate equipment in each of the clinics, including arrangements for managing and disposing of waste. We observed portable equipment such as baby-weighing scales were well maintained and calibrated before use.
- Staff received training in using various items of equipment but formal staff competency assessments were not in place to provide assurance in all services.
- The environment was not always practicable for the clinics being conducted by staff especially where the location was not owned or managed by the trust. At Cotham Surgery baby clinic, the room in use was not suitable. The room was too small to safely accommodate three staff members and two sets of parents with their babies at one time. The privacy screen was not used meaning conversations between all parents could be overheard and we heard one particular sensitive conversation being overheard by another parent.
- The environment in schools where immunisations were being carried out did not always promote a calm and safe environment.

- We noted facilities such as hand washing sinks and bins were not always readily available or close to where staff conducted the clinics.

Quality of records

- There was a combination of paper based and electronic patient record (EPR) throughout the different teams and specialities.
- There was a clear standard operating procedure for the management of records specific to the children and families service. Staff were aware of this procedure and the records reflected adherence.
- Teams such as the health visitors and school nurses only used the EPR. The EPR was secure, easy to navigate and staff could track patients through the services they received at the trust and could share information with all the professionals involved. Staff completed standard templates according to the pathway or therapy patients were following.
- The EPR alerted staff to any confidentiality and information sharing permissions for any given patient as well as any alerts needed to be considered such as any previous safeguarding issues or if the patient was known to the children looked after (CLA) team.
- We looked at electronic patient records, they were up to date and accurately completed. Records included a comprehensive assessment process as per each template and contained information about referral, triage assessment, admission to caseload, appointments, consent forms and care plans.
- Although EPR was enabled on specific laptops, poor network connectivity of the laptops meant community staff recorded information in the patient held records, their own paper records and then transferred the information electronically upon return to the office base. This meant a duplication of effort and a risk of transcription errors when staff updated the electronic record.
- The EPR could not link in with other electronic patient systems used by the mental health community teams to track and record patient information. The contraceptive and sexual health (CaSH) service had a standalone system in line with the regulations. Staff told us due to the systems not linking in; there was some duplication of work and potential for information being overlooked.
- Electronic templates had not been set up for all the specialities, which meant they continued to maintain paper records, which could not be accessed across other specialities.
- Babies and younger children attended drop-in wellbeing clinics where they brought their own child health records or “Red Book” with them. This is a book given to parents upon the birth of a child to record observations and outcomes from any clinics they attend as well as to record immunisations. The red books were not always fully completed with names and address of the children.
- Clinic staff, such as the health visitor, completed one-page carbon copied sheets called “Flimsy’s”, kept one copy, and placed another in the red book. The policy was to complete the paper flimsy and then the associated EPR within 24 hours but this was not always occurring due to the lack of availability of electronic hardware and clerical staff to input this information as well as other clinics being scheduled in-between. This led to children’s records not being kept up to date in a timely manner.
- We saw evidence of poor quality of scanning of these ‘flimsy’s’ where they were illegible once scanned onto the child’s electronic record. This was against the service’s policy on record keeping.
- We noted one occasion where health visitors did not record full details of the care planned and any decisions that were made on a flimsy and told us anything contentious should not be on the flimsy to protect the child. The understanding of what should be recorded varied between the staff we spoke with.
- The service’s policy on record keeping clearly identified this information should be written in the main body of the record and not on ‘flimsy’s’ scanned into the system.
- Paper records had mounted up in the bases whilst the service was going through the transition process of scanning all of the paper records into the system.
- Some children had hard copy paper records in their home, which were collected and archived at the end of an episode of care and entered into the electronic system.
- Drop in clinics did not always have all the information needed at hand. This made it difficult to see the history of treatments, especially if different staff attended

clinics in different areas. Staff did not have the appropriate means to access the electronic systems on site as they were running many clinics from other provider's premises.

- The management team told us they were working on a solution to promote the EPR so all the teams were working together. The current contract was ending and the organisation were at a pre-procurement stage at looking at new systems. The process for clinical records was difficult because it was hard to fit one model across the trust.

Cleanliness, infection control and hygiene

- Staff were aware of infection prevention and control guidelines. We observed staff following the 'bare below the elbow' guidance and wearing personal protective equipment, such as gloves and aprons, whilst delivering care.
- Staff were not always washing hands or using hand gel between patients. We noted staff at the baby drop in clinics did not always washing their hands between weighing each baby. Access to hand washing sinks was not always available as clinics were held at premises not owned by the trust.
- Sharps were placed in appropriate sharps bins immediately after use ensuring safety of the staff, patients and the environment.
- Infection prevention and control link nurses were assigned to each team to inform staff of any updates to practice or procedures.
- We observed equipment was clean following protocols. We noted equipment, such as weighing scales and changing mats were cleaned between each baby weighing at the clinics. However, we saw one staff member cleaning the baby mat, the weighing scales and the table surface with the same wipe. This was not hygienic as it allowed for cross contamination but the overall potential risk to patients was small.

Mandatory training

- Staff received an induction specific to their role when they started work in their department.
- Induction checklists included departmental orientation, safety instructions as well as policies and procedures. These had been signed by staff and their supervisors.

- Mandatory training content and frequency differed for clinical and non-clinical staff. Staff received mandatory training in areas such as infection prevention and control, moving & handling and safeguarding children.
- Role specific training included areas such as immunisation & vaccination and training around risk awareness.
- Training was delivered via a structured programme by a combination of face-to-face sessions and access to some modules through the intranet.
- At the time of inspection, the trust's centralised mandatory training system showed the target of 85% attendance for mandatory training was not being consistently met within the service. Completion for training such as basic life support was at 64% at the time of the inspection. Overall compliance was 83.9% at January 2015. However, following the inspection, the trust told us their local system showed the compliance rate was being met.
- Staff within Avenham health centre told us they could not access mandatory training other than role specific training due to long-standing staff shortages. Staff felt it was difficult for them to afford the time for training and they felt it was stressful for them.
- Health visitors and school nurses in focus groups told us it was difficult to attend training due to where it was located geographically and travel time was restricting.
- Staff not employed directly by the organisation received training from their employing organisations such as agency staff and consultants. Assurance was obtained from their primary employer in relation to the core modules.

Assessing and responding to patient risk

- Care plans were in place for children with complex needs whose condition may deteriorate with a named contact provided for the families.
- Within the Children's Integrated Therapy and Nursing Service (CITNs), a team of specialist nurses worked with children with complex needs in the community and within specialist schools in the area. These children had comprehensive care plans in place for continuity of care. For a small number of relevant children, an end of life plan was in place. This plan was implemented by the hospital consultant and was followed by all health

professionals working with the child. These children had open access to the hospital to ensure urgent medical attention could be accessed at different times of day and night if needed.

- Risk assessments were in place for areas in the trust such as treatment rooms and clinics.
- We requested the most recent risk assessments for staff using clinics not owned by the trust. Not every clinic location had one available at the point of care, staff were not always aware of them and some did not have one at all.
- The risk assessments supplied were not comprehensive and had many areas omitted from them. The assessments were basic and mainly environmentally centred. They did not take into account risks and activities such as hand washing or how many children could be seen in the space available. We saw issues such as communal toys, not owned by the trust, being played with by children waiting to be seen at baby clinics not being effectively cleaned between use. These risks were not taken into account. We also noted many of these had just been undertaken before our inspection.
- Prior to the immunisation session in a school, the immunisation nurse should visit the school and complete the risk management to ensure a safe environment is available prior to the immunisation session. This assessment should be reviewed and dated prior to subsequent immunisation sessions during that same academic year. The risk assessment for the school immunisation session did not include staff waiting after vaccinations to check students didn't have a reaction, hot drinks being served or risk of anaphylaxis but only had generic issues such as parking facilities and availability of first aid.
- We noted hot drinks were provided during one baby clinic session. Signage was on the table to identify the risks of young children going near the hot drinks and outlining the trust would not be held responsible for any accidents involving hot drinks. We observed a child climbing onto the table during the clinic without any member of staff intervening. We also observed a young child going into the kitchen with an accessible hot water dispenser. No member of staff advised against the child being in the kitchen.

Staffing levels and caseload

- Staffing levels and caseload mix was determined using a number of recognised national acuity tools as well as in-house methods.
- The health visiting and school nursing teams used The Benson Model (a tool to look at a fair distribution of staff within the teams looking at caseload numbers, geographical area and numbers of children and families with complex needs). A review using the Benson Wintere model was being undertaken for the health visitors and school nurses. Staff felt involved in this review.
- Some areas used a weighting tool which incorporated risk assessments and a traffic light system to review the number and acuity of children and young people who needed to be seen and adjusted staffing levels accordingly.
- An in-house tool determined the amount of time staff were available for work and took into account all activities staff undertook such as supervision, meetings, mandatory training (over a three-year period) as well as supervision. This data had been reviewed and analysed to account for peaks and troughs in attendances and used to inform staffing numbers across various teams.
- The Health Visitor Implementation Plan (a national plan to increase the numbers of health visitors nationally by 2015) was at 259 whole time equivalent (WTE) at the time of the inspection out of the 261 WTE health visitors required.
- However, staffing levels were not met in a number of teams including the health visitor staffing levels at Avenham Health Centre which were below the identified staff levels by 2.5 WTE. Staff at the centre identified this as a long-standing issue as it had been difficult to recruit to this geographical area due to the workload demands. The health visitor and school nursing teams across the Preston area were also identified as being below full establishment by 3.97 WTE at the time of the inspection.
- Staffing and caseload across the teams was not consistent. The highest caseload numbers were in the North West team of health visitors, where the caseload numbers were 435 patients per WTE.
- Staff felt the high caseloads weren't always manageable and the high numbers meant they couldn't always carry out all the required assessments or maintain a healthy portfolio relationship.
- The teams told us they felt stretched and busy but felt this did not compromise children and young people's safety.

- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or by agency nurses to provide cover at short notice. The organisation carried out checks on all agency staff to ensure they had the right level of training in delivering emergency care.

Managing anticipated risks

- Nurses completed patient risk assessments as part of an initial assessment. We saw specialist teams had specific risk assessments which were completed.
- Lone working policies were in place and staff followed them. The computerised record system had an alert system so staff were aware of any potential risks when carrying out visits. Staff told us of the trust's protocols for arranging, and carrying out home visits. Staff told us sharing information on risks with partner organisations was generally effective.
- Staff in each base had a staff huddle at the start of every day, where discussions included which home visits staff were to undertake that day and time they were expected back.

Major incident awareness and training

- A major incident plan listed the key risks that could affect the provision of care and treatment provided by the trust. There were clear instructions in place for staff to follow in the event of a major incident with a response section and action cards. Actions specific to the children's and families network included having an out of hours pathway working with the children's social care teams and staff making a determined effort to keep children and parents together.
- Staff were aware of major incident plans and described the action they would take for eventualities such as snow, floods or staff shortages.
- There was a comprehensive procedure for a major outbreak of disease which would require mass vaccinations being given within school settings, for example a Meningitis B outbreak. Staff were aware of this procedure including who to contact.

Are services effective?

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

The trust target to achieve 90% uptake by 31 August 2015 was not yet met as the actual uptake ranged from 59% to 73% at the time of inspection with four months remaining. The vaccination and immunisation team target at 90% was not met due to a considerable amount of unreturned consent forms and low take up rates within Muslim communities declining the vaccination that contained porcine gelatine.

There was no routine antenatal contact by the health visiting team at the time of the inspection where breastfeeding support and advice should be given.

Staff in the vaccination and immunisation team were not always following the trust's consent policy in relation to the Gillick competency and Fraser guidelines which resulted in some children not being vaccinated or the parents being contacted to gain verbal consent.

Although electronic patient records were easily accessible, where connectivity to the trust system was good there were instances reported of poor connectivity and access to paper based records was variable throughout all areas. Policies, procedures and relevant information were not always available at all the clinics we visited, as they were not all owned by the trust.

Trust records showed, as of March 2015, only 54% of all staff had received appraisals for the year 2014 to 2015.

The coordination of CLA who were under the care of the local authority (Lancashire County Council) was a challenge especially when the child was placed out of Lancashire's boundaries as the LCFT CLA nursing teams had to coordinate the referral, discharge and transition of the child with social services teams from all over the country to perform assessments.

There was no identified lead to assist with issues of learning disabilities and their management of younger people with learning difficulties was a grey area.

Evidence based care and treatment

- Care and treatment was evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Each area of mandatory training was linked to the appropriate standard for example; infection control training had been linked to NICE guidelines [CG139] - Infection: Prevention and control of healthcare-associated infections in primary and community care.
- Clinical pathways, such as the developmental musculoskeletal pathway in physiotherapy, were developed and referenced with associated nationally recognised standards such as the British Thoracic Society (BTS) and the Association for Chartered Physiotherapists in Respiratory Care (ACPRC).
- The Children's Integrated Therapy and Nursing Service (CITNs) had evidence-based pathways in place for specific areas, including dysphagia, Autism Spectrum Disorder (ASD) and speech impairment, which ensured consistency of approach.
- Update to guidance and any changes to practice was accessible to staff electronically and regularly discussed at local meetings around the team information board.
- Staff undertook local audits to assess how well guidelines were adhered to. All of these audits resulted in staff education and changes in practice to improve patient care. A local audit in relation to consent had been conducted and actions had been clearly identified and acted upon.

Pain relief

- Care plans were in place where appropriate and pain relief was administered as required for children such as those with long-term conditions or children with complex needs and those who required ventilation.
- Within the special school, pain relief was included in the child's individual care plan where relevant.
- Nursing staff told us pain relief was supported with the use of appropriate positioning e.g. use of special beds, mattresses and adapted wheelchairs with specialist seating.

Are services effective?

- Clear guidelines existed for staff in relation to palliative care and staff had received appropriate training.
- The vaccination and immunisation team offered advice to young people following injections on safe use of paracetamol in case of pain or fever during the day of vaccination.

Nutrition and hydration

- There was no routine antenatal contact being carried out by the health visiting team at the time of the inspection where breastfeeding support and advice should be given.
- The trust informed us the routine health visitor contact became part of the contract in April 2014. However, it was agreed with commissioners this was introduced on an incremental scale starting with those deemed most vulnerable as highlighted by children's centres and midwives.
- Children within the CITN service that required support with feeding had comprehensive care plans in place to support this.
- Specialist nurses for children with complex needs provided training to parents and other relevant health professionals on the use of feeding equipment.

Technology and telemedicine

- The contraceptive and sexual health (CaSH) service had a dedicated and confidential telephone line prospective clients could call. Advice was available on services provided within the trust as well as emergency clinics and other services provided by nearby organisations.
- Clients were offered a telephone appointment and advised a nurse would ring them at the pre-arranged appointment time for a consultation lasting between 10 to 30 minutes. Clients were advised to be in an area with good reception (if on a mobile phone) and in a private place. The nurse would undertake the assessment. The current "did not attend policy" allowed two unanswered attempts.
- Health visitors were given electronic tablets to allow access to records whilst in clinic settings or during family visits. However, staff informed us there was often no signal to enable them to use this technology at appropriate times. We did not observe any staff using this technology in the clinics during the inspection.

- Printing out blank templates to take on visits caused issues because printers were not always available which meant all the information required was not always gathered on the visits.

Patient outcomes

- The trust target for the vaccination programme was to achieve 90% uptake by 31 August 2015 as an aspirational target as agreed with commissioners. The actual uptake ranged from 59% to 73% at the time of inspection with four months remaining.
- The vaccination and immunisation team told us the school vaccination programme target was at 90%, being much higher than the actual uptake achieved. The trust achieved 47% compliance ranging from 58.57% in Central Lancashire to 30% in Blackburn with Darwen. The commissioned target for flu during 2015 to 2016 is set at 40-60%. The trust identified there were a considerable amount of unreturned consent forms and take up rates were affected within Muslim communities with young people declining the vaccination which contained porcine gelatine.
- The trust uptake for DTP vaccination ((also DTwP) refers to a class of combination vaccines against three infectious diseases in humans: diphtheria, pertussis (whooping cough), and tetanus) was at 61% which was lower than the national uptake of 70% at the time of inspection.
- An audit regarding accurate consent taking, and staff understanding of who could actually give consent, was conducted across the Children's Integrated Therapy and Nursing Service (CITNS), in September 2014. This audit was the initial step in identifying current practice and potentially other problems not yet known. The overall compliance was 87%, above target compliance of 80%. Some concerns regarding consent were noted in the teams at Hyndburn, Ribble Valley and Rossendale and Burnley and Pendle. The findings and current practice were discussed with each team.

Competent staff

- Trust records showed appraisal rates varied between the children and families teams. As of March 2015, only 54% of all staff had received appraisals for the year 2014 to 2015. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager.

Are services effective?

- Some teams such as the speech & language therapy (SALT) and universal services teams had achieved 100% compliance whilst the nursing students only achieved 4% and the universal health management team only achieved 22%. Staff told us they had either received an appraisal or were due to have one and the process was still ongoing.
- Staff told us they generally felt very well supported and cared for by their managers. We saw effective systems for staff one-to-one supervision and peer group support in areas such as safeguarding children.

Multi-disciplinary working and coordinated care pathways

- We observed collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of care. Staff from all the teams and specialities discussed the needs of children and their families to promote an effective handover.
- Collaborative and multiagency working was observed, for example, the teams within the CITN service were all co-located and managed as one team, which meant each team knew the numbers and type of patient ready to be transferred to them.
- Daily meetings, involving the nursing staff, therapists and external agencies were conducted to ensure there were sufficient support teams, specific pathways, management plans and confidential systems in place.

Referral, transfer, discharge and transition

- The children looked after (CLA) team managed the health needs of children and young people with complex health needs, aged 16 years and over, those not in education and those not known to universal services. The nursing team was responsible for the co-ordination of health needs for children and young people, including statutory health assessments and managing the smooth transition of health records, sharing of information and services required by the individual, both in and out of the child's originating area. This applied also to those children placed within the boundaries of Lancashire from out of area.
- The coordination of the health needs of CLA was a challenge especially when the child was placed out of area, as the team had to coordinate the referral, discharge and transition with social services teams from all over the country to perform assessments. The CLA

team were not consistently made aware when children or young people were placed in Lancashire which delayed access to the necessary health services and thus preventing the health needs of the child being met within a timely manner.

- The CLA team had no influence over the notification processes in place outside of the Lancashire boundaries. This affected the completion of the statutory initial health assessments that should be completed within 28 days of a child/young person entering care.
- Paediatric liaison notified relevant services of all children that attended at Accident and Emergency (A&E) Departments. This was a paper copy form that was either filed in the paper records or scanned onto the EPR system.
- The transition of young people's care into adult services had been identified as an issue. However, the trust had been successful in a bid to improve this transition working with a neighbouring trust. This project was in its early stages and the first engagement meeting had been attended where young people and their carers had been involved in the planning stages.
- Work was being undertaken around the transition of children with long-term conditions and those with learning disabilities to adult services.
- The child psychology service (CPS) had a transition protocol in place for transitioning children to adult services but felt where younger people with learning difficulties were involved this was a grey area within the trust and patchy. There was no identified lead to assist with issues of learning disabilities.
- Some children saw it as a big change between being treated by a paediatrician as opposed to a consultant who predominantly treated adults. Some teams worked across the transition with the children to promote a seamless transfer. There was a grey area around the definition of age of younger adults and when they would be transitioned.
- The transition from nursery to primary school and then to high school also proved difficult for some children and families.
- The children and families network had realised it was not compliant with the trust policy of discharge, transfer and hand over of patients. A new trust protocol had been shared at the network Clinical Effectiveness Group Service Lines to develop service line specific standard operating procedures.

Are services effective?

Access to information

- Electronic patient records were easily accessible where connectivity to the trust system was good. Access to records in the clinics or during home visits was not always possible due to the ineffective connectivity and lack of availability of electronic hardware.
- Information about the patient such as medical information and assessments was readily available, where electronic, across all the teams so they could coordinate their services. Staff collated and checked all the information before the patient was transferred or discharged.
- Access to paper based records was variable throughout all areas.
- Policies, procedures and relevant information was not always available at all the clinics we visited as they were not all owned by the trust. Staff told us there was a policy for follow up procedures when a child had had several admissions to A&E, however, they could not locate this during the inspection. The trust confirmed there was no policy at the time of inspection but the process was outlined elsewhere. We could not be clear whether the correct recording and follow up procedure was applied when a child had had several admissions to A&E.

Consent

- Staff had the skills and knowledge to ask children and their representatives for consent and explained how they sought verbal and implied informed consent.
- Staff used the Gillick competency and Fraser guidelines (used to decide whether a child is mature enough to make decisions) to balance children's rights and wishes with the responsibility to keep children safe from harm.
- Patient records showed verbal or written consent was obtained appropriately from children or their representatives.
- The contraceptive and sexual health (CaSH) service staff used the Gillick competency and Fraser guidelines to ascertain if children had the capacity to consent.
- The electronic system in the CaSH service recorded and flagged up on the front page exactly who any information could be shared with e.g. the GP or family. This was a joint process with the young person who would negotiate what to put into the notes.
- Staff in the vaccination and immunisation team were not always following the trust's consent policy in relation to the Gillick competency and Fraser guidelines, which stated children in school year 10 (aged 15-16) could give consent if deemed to be Gillick competent. We observed occasions when Gillick competency was not used at all and resulted in children not being vaccinated or the parents being contacted to gain verbal consent. The team leader of the immunisation session would always seek the consent of parents prior to vaccinating the young person with the exception of young people whose parents did not have a good understanding of the English language.
- A potential risk regarding accurate consent taking, and staff understanding of who could actually give consent, was identified during 2013. An audit was conducted across the Children's Integrated Therapy and Nursing Service (CITNS), in order to identify actions required to provide assurance that consent is obtained consistently and in a valid manner across the service.

Are services caring?

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

Parents, carers and children were positive about the care and treatment provided. They felt supported, involved and received information in a manner they understood. The NHS Friends and Family Test results showed the majority of patients would recommend the department to their family and friends. Patients felt they were afforded sufficient privacy and dignity. However, in the vaccination clinic, young people only had a gown to protect their modesty whilst in view of other young people and female students were asked if there was any chance of pregnancy in the open hall without due consideration to their privacy.

Staff were compassionate, kind and respectful whilst delivering care. We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Staff provided reassurance and comfort to people who were anxious or worried.

Compassionate care

- Children, young people, their families, relatives and representatives were positive about the care and treatment provided. Parents at a baby clinic described positive experiences with the health visitors and explained how they handled babies with compassion and care.
- We observed many examples of compassionate care given to children, young people and their families based on individual needs.
- The NHS Friends and Family Test had a good response rate within the children and families service. The results showed that the majority of patients would recommend the department to their family and friends. Comments were received about how compassionate the staff were and how friendly and caring they were. Almost all (99%) of respondents felt that they were treated with dignity and respect.
- We saw patients' cubicle curtains were closed during consultation and staff spoke with patients in private to maintain confidentiality. Patients felt they were afforded sufficient privacy and dignity. However, in the vaccination clinic, young people unable to roll up their shirtsleeves had to expose the top of their arms with only a gown to protect their modesty whilst in view of

other young people waiting for their vaccinations. Female students were also asked if there was any chance of pregnancy in the open hall without due consideration to their privacy.

Understanding and involvement of patients and those close to them

- Parents and young people received information about their care and treatment in a manner they understood.
- Parents and young people were involved in the planning of their care. Within the Children's Integrated Therapy and Nursing Service (CITNs) parents were involved in writing the child's care plan with all the professionals involved in the care and only signed the completed plan once they were satisfied with it.
- Upon admission to a caseload, patients were allocated a designated staff member to oversee all the care they received to ensure continuity of care.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Patients confirmed their consent was sought before care and treatment was delivered.
- Patients and those close to them were also involved in the planning for discharge from the department.

Emotional support

- We observed many positive interactions of staff providing reassurance and comfort to people who were anxious or worried.
- Emotional support was given to children and young people who were being treated. We observed young people receiving emotional support from a member of the vaccination team during their vaccination due to being afraid of the procedure.
- During clinics we observed a caring and supportive environment to allow parents to speak openly. Staff were seen giving young people and parents time to talk and reflect.
- We observed a newly formed baby weigh, stay and play group that was managed by one health visitor and two members of staff from the local children's centre in a rural location. Staff told us that one key purpose of this group was for parents with young children to meet other

Are services caring?

parents and carers who had had similar experiences and similar situations as themselves and was another way of offering emotional support to ensure people were not feeling isolated.

Are services responsive to people's needs?

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

The diverse population including travellers, seasonal workers and local ethnic minority groups were well responded to by the children and young people's services. Clinics were arranged with both allocated and drop in appointments and from various settings to meet the needs of people in rural areas.

The speech and language therapy service had employed two members of staff who were bi-lingual. Staff conducted in-reach clinics where they went out to children and families for immunisations and vaccinations. There was also a diverse student population in Preston and staff worked with the colleges and universities to configure teams to have an appropriate skill mix and a base within different campuses to form a multi-agency approach.

The trust had a "Cygnets" programme aimed at parents with children with behaviour issues such as autism, sensory and communication issues. This was well attended by parents who were supported in a group and individually to understand and gain appropriate skills to build confidence with their children.

No teams had national guidelines for waiting times for appointments but the trust had set a preliminary nominal target of seeing referrals within 18 weeks. Data supplied showed waiting times varied in each speciality and from area to area. Overall, from April 2014 to March 2015, the average percentage of referrals waiting over 18 weeks for all services had decreased from 10% to 3% and the referral waiting the longest time to be seen had reduced from 22 to 16 weeks.

One of the challenges for the service was the increased acuity of patients, demand and reduced resources. The needs of children in the community had increased, as there were no other services to assist them. Complaints were managed effectively and feedback was shared to help staff learn from them.

Planning and delivering services which meet people's needs

- At the time of the inspection, there was no specialist child development centre in Preston. To respond to the gap in the service, the Children's Integrated Therapy and Nursing Service (CITNS) had set up a specialist group at a Children's Centre in Preston.
- A 'buggy boot camp' within the Ribblesdale area addressed the needs of mothers at risk of postnatal depression and isolation. This group was in its early stages but had received positive feedback from mothers who had used the service.

Equality and diversity

- The speech and language therapy service had employed two members of staff who were bi-lingual, as they had recognised the need for this within their area. They covered several different languages. This had been beneficial to the service as within speech and language therapy staff had struggled to engage children and young people when an interpreter was also involved.
- Another diverse population within the area was the rural and travelling communities. Management told us the actual geographical rural places were not an issue and staff conducted in-reach clinics where they went out to the children and families for immunisations and vaccinations.
- Farmers brought in seasonal workers and families from abroad which increased workloads and had to be accounted for every year.
- There was a diverse student population in Preston, staff worked with the colleges and universities to configure teams to have an appropriate skill mix and a base within different campuses to form a multi-agency approach.
- The Healthy Child Programme was managed between the health visitors and school nurse. However, an antenatal contact was not being routinely offered universally as identified in the trust document 'Services for Children and Young People with Special Educational Needs and Disabilities'. We were informed antenatal contacts were being offered to mother's identified as at greater risk in their pregnancy or where safeguarding concerns had been identified.

Meeting the needs of people in vulnerable circumstances

Are services responsive to people's needs?

- One of the challenges to the service was the increased acuity of patients, demand and reduced resources. The needs of children in the community had increased, as there were no other services to assist them.
- Each child in the Children's Integrated Therapy and Nursing Service (CITNs) had an individual school management plan and care plans if they became hospitalised. These plans were written in partnership with the parents, nurses and head teacher. The special school nurses provided training to teachers and teaching assistants in schools to ensure continuity of care.
- Clinics had been set up in local children's and community centres to enable families to attend that lived in rural areas or had difficulties with transport. This enabled the service to be accessible to a larger number of families. Health visitor clinics were mainly run on a 'drop in' basis to give a greater degree of flexibility for families.
- We observed school nurse 'drop-in' sessions being conducted at high schools on a weekly basis to allow young people the opportunity to discuss any issues they had in a confidential and safe manner with a health professional. These sessions were well advertised and young people were aware of when the sessions were and how they could access them.
- The trust had a "Cygnet" programme aimed at parents with children with behaviour issues such as autism, sensory and communication issues. This was well attended by parents who were supported in a group and individually to understand and gain appropriate skills to build confidence with their children.
- No teams in the children and families network had national guidelines for waiting times for appointments. The trust had set a preliminary nominal target of seeing referrals within 18 weeks.
- Data supplied by the trust showed waiting times varied in each speciality.
- At the end of June 2014, data showed the child psychology team in Blackpool had the highest percentage (26%) of referrals waiting over 18 weeks with the longest wait at 26 weeks. This reduced to the longest wait being only 10 weeks and 0% waiting over 18 weeks by the end of March 2015. The CITN service had a waiting time of 13 weeks.
- Times also varied within teams at different geographical locations. The physiotherapy teams had differing percentages of referrals waiting over 18 weeks in three areas; West Lancashire (6%), Chorley and South Ribble (0%) and Greater Preston (8.5%) in June 2014. The trust had reduced the percentage of referrals waiting over 18 weeks to 0% in the West Lancashire and Greater Preston teams by March 2015, but the Chorley and South Ribble percentage of referrals waiting over 18 weeks had increased to 7%.
- Overall, from April 2014 to March 2015, the average percentage of referrals waiting over 18 weeks for all services had decreased from 10% to 3% and the referral waiting the longest time to be seen reduced from 22 weeks to 16 weeks.
- Waiting times for patients once they had been accepted in a team were short after being booked in. Young people and representatives of children confirmed they did not wait long before they were seen. Staff told us they would let patients know individually if there were any unforeseen delays. If a clinic was cancelled at short notice, staff would attempt to contact the patients and offer alternative times.
- Families were asked to opt in for an appointment with the therapists, to limit missed appointments and were given a choice of appointment times.
- The service regularly monitored people who did not attend (DNA) their appointments. Actions had been taken to ensure all the patients' attended their appointments at the right time. The service sent letters daily, at least a week in advance of appointments.

Access to the right care at the right time

- There were set clinics, for all specialities, on a weekly basis with walk-in slots such as the baby well-being clinics as well as clinics that required pre-booked slots. The therapy services had an open referral process where families could self-refer. This reduced the actual time that families had to wait to receive an appointment.
- Younger children often had drop in clinics where they could attend at their convenience but older children had less choice and a more strict appointment time.
- This ensured staff knew when they could book patients in for specific specialities and enabled the appropriate support staff to be present

Are services responsive to people's needs?

- Some services had trialled following up appointments by sending a text message 24 hours prior to the appointment. This saw a drop in the number of DNA's, however, the electronic systems were not currently in place for this to become embedded.
- Patients who did not attend for any reason and were referred via the CLA team were not automatically struck off due to the nature of children attending. They were given further opportunities to rearrange the appointment before they were discharged from the service.
- Operational challenges, such as provision of non-commissioned services, also affected the trusts ability to deliver a consistent service. The management team felt they had a duty of care to provide positive outcomes.
- A trust wide policy included information on how people could raise concerns, complaints, comments and compliments with contact details for the Patient Advice and Liaison Service (PALS).
- Information was displayed in the clinics about how patients and their representatives could complain.
- Complaints were recorded on a centralised trust-wide system and monitored as part of the trusts quality indicators. There were 55 complaints received in the children's and families network within a twelve-month period prior to the inspection, of which 46 were upheld.
- We saw a number of "you said, we did" boards identifying changes that had been made from complaints and other patient feedback.
- Staff understood the process and told us information about complaints was discussed during routine team meetings. Staff could give examples where parents had complained to the service and how this had been managed with full involvement of the parents and staff.

Learning from complaints and concerns

Are services well-led?

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

Staff clearly expressed the trust's vision and values and portrayed positivity and pride in the work they did. Risk registers captured departmental risks and issues such as non-completion of mandatory training and equipment. There was effective teamwork and visible leadership across the teams.

Public and staff engagement was imbedded and included initiatives such as a partnership with Hyndburn Council and Public Health Lancashire in the launch of a voluntary ban to encourage people not to smoke in Council Play Areas and working with people from the community to conduct research studies about how cultural beliefs had prevented access to healthcare. The Early Start Team felt proud and honoured to have their hard work and efforts recognized with a National Nursing Times Award.

Service vision and strategy

- The vision was “To provide 21st century healthcare with wellbeing at its heart” with six values to deliver this “Teamwork, Compassion, Integrity, Respect, Excellence and Accountability”.
- The trust's priorities, outlined in the “Operational plan (2015/16)”, incorporated this vision and included specific strategic objectives applicable to the children's and families network such as quality improvements linked to cost savings and efficiency.
- The trust engaged with people and used feedback from stakeholders to influence their strategy.
- Staff we spoke with had a good understanding of the vision and strategies and what was required to achieve these.

Governance, risk management and quality measurement

- The risk register included risks (rated from low to high) for the children, young people and family's network. Progress and improvements were monitored through regular quality and governance meetings.
- The three highest risks as of February 2015 were staff not completing mandatory training in the timescales,

equipment and the threat of non-delivery of physiotherapy pathways due to lack of a hoist at Sir Tom Finney School. All three risks had been added to the risk register in February 2105.

- Staff were aware of their departmental risks and issues such as information around complaints, incidents and audit results which were shared in the departments.
- A central team recorded and reported performance activity and quality measurement within the trust. The service were trying to improve the culture around the robustness of data in the network by addressing issues around collation as some was electronic and some paper based.
- The organisation was meeting targets set nationally in areas such as 7-day follow-ups and from the Care Programme approach (CPA).
- Some services had very few key performance indicators (KPI's) but staff were working with the multiple clinical commissioning groups (CCG's) to review the substance of KPIs and service level agreements to ensure the trust was meeting contractual needs.
- One of the corporate visions was to have assurance of information for the top measures in a fully automated process. The performance and information teams were piloting dashboards to capture the relevant data.
- The organisation had Quality Safety, Experience, Effectiveness and Leadership (QSEELs) in place for the clinical teams to measure how well they were performing in areas such as safeguarding.

Leadership of this service

- An organisational structure and framework was in place for the children and families network.
- There were clearly defined and visible leadership roles in the local teams.
- The director for children's services and the clinical director for children's services had overall responsibility for the network. They worked to influence stakeholders to have positive outcomes e.g. the directors had presence on various children's boards such as the parenting group in Blackburn.

Are services well-led?

- Daily management of the various teams was delegated to appropriately qualified staff in each speciality at band 6 or 7 to ensure locally visible leadership. The teams appeared to be motivated and worked well together.
- Senior staff said, “We are proud of the teams, they deliver high quality care and listen and respond to patients needs in a caring manner”.

Culture within this service

- There was a positive attitude and culture within children’s services. The overall ethos centred on all the services working together with best practice coming from the whole group rather than any individual. Staff felt patients received high quality, evidence based, safe care.
- Teams were not always located together in the same building, but staff morale within the different teams was good. Teams applied a multi-agency approach to working with other organisations such as social services so children and young people received the most appropriate care and treatment.
- The commissioning of health visitors and school nursing services were being transferred to the Local Authority. Some staff were not clear about how the transition to the Local Authority would take place. They reported there had been no preparation around the impact on their job role.
- Staff were also concerned about the extent of the service restructure within Lancashire Care NHS Foundation Trust over the past three years with some support staff relaying concerns they had been fearful of losing their jobs three times over the last three years.
- The staff sickness rate was 4.81% between April 2014 and March 2015. The majority of teams had very low sickness rates but a few teams such as the East Lancashire family planning and sexual health team had 11% sickness and the Central Lancashire physiotherapy team had 36% sickness. Average staff sickness for the service was at 4.75% within the month prior to the inspection.
- Staff had attended funerals where they had worked with children on end of life pathways or children with complex packages.
- Staff could access counselling and post-traumatic stress services provided by the trust via the phone or attend face-to-face consultations following involvement in any serious incidents, whilst working with children with complex needs or if involved in child deaths.

- Managers had received training to support staff and had access to a “first aid kit” (an internal set of tools such as information for counselling services).
- Support was also available during group and individual supervision.

Public engagement

- School needs health questionnaires were completed for children four times in their school career. If any further needs were identified then the children were referred to other services such as a dietician or the speech and language therapy team. Results were sent to parents or guardians but recently results were also sent to the older children/younger adults to allow them to be more involved.
- The trust had worked in partnership with Hyndburn Council and Public Health Lancashire in the launch of a voluntary ban to encourage people not to smoke in Council Play Areas. Following consultation with 181 play facility users, it was revealed that 71% of people would strongly support a voluntary ban. Following full consultation, full council sign up was achieved to implement the voluntary code of conduct & signage was placed across all council play areas. Signs were designed by two pupils from St Mary’s RC Primary School in Oswaldtwistle.
- The teams were working with people from the community to conduct research studies about how cultural beliefs had prevented access to healthcare. One study around the use of faith healers had led to the trust targeting the family unit, rather than just the patient.

Staff engagement

- Staff received communications from an organisational level such as newsletters and attended team meetings. Overall staff felt they were listened to and felt supported, however, the inconsistency and variability in communication with staff, meant that some staff did not feel well engaged with senior managers.
- The trust were hosting “Dare to share” events in summer 2015 and autumn 2015 to share examples of positive and negative interactions the teams had been involved in such as court reviews, coroners reviews and action involving professional bodies.
- The Early Start Team felt proud and honoured to have their hard work and efforts recognized with a National Nursing Times Award.

Are services well-led?

Innovation, improvement and sustainability

- The Health Improvement Service implemented “Building Community Capacity” throughout LCFT children and families health service teams; it was also part of the national health visitor implementation plan. Children and families health service teams worked alongside individuals, communities and partners to help achieve the best possible outcomes for their health and wellbeing. Building Community Capacity activities could be a project, a system or an initiative such as a baby yoga group or an emotional health group.
- A taskforce had been set up to work towards the “Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing” national road map set out by the Department of Health. Implementation was proving difficult due to there being eight clinical commissioning groups to engage.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12: Safe care and treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12

We found risk assessments were not available for all areas we inspected, staff were not always aware and therefore not mitigating the risks. They were poorly written and assessed and the premises used by the service provider were not always safe to use for their intended purpose. 12(2) - (a)(b) & (d)

We found the cold chain was not always maintained for vaccines, monitoring for adverse reactions was not undertaken, and appropriate guidance was not always followed when taking consent. 12(2)(g)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18: Staffing

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18

We found low staffing numbers in some teams resulted in high caseload and staff not being able to complete all the required tasks in a timely manner. The teams at Avenham Health Centre and across the Preston area had particularly low numbers. (1)

We found the trusts centralised system for mandatory training and supervision was not always accurate and up to date and did not reflect the local figures. (2)(a)