



Meeting Date	25 November 2021	Agenda Item	2.1
Report Title	External Review of the Children’s Community Nursing Team Service		
Report Author	Hazel Lloyd, Assistant Director of Governance		
Report Sponsor	Gareth Howells, Executive Director of Nursing & Patient Experience		
Presented by	Gareth Howells, Executive Director of Nursing & Patient Experience Hazel Lloyd, Assistant Director of Governance		
Freedom of Information	Open		
Purpose of the Report	To provide the Board with the findings of an external review of the Children’s Community Nursing Team Service and set out the actions being taken in response to the recommendations.		
Key Issues	<ul style="list-style-type: none"> • Executive Team commissioned an external review of the Children’s Community Nursing Team Service following concerns raised by families and the Executive summary is attached as Appendix 1; • Section four sets out the response being taken to support families; • Recommendations of the review are set out in section five and Appendix 2; • Improvement plan is attached an Appendix 3. 		
Specific Action Required (please choose one only)	Information	Discussion	Assurance
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Recommendations	Members are asked to: <ul style="list-style-type: none"> • CONSIDER the findings of the report and implications of the quality of the service in the Health Board. • APPROVE the action plan in response to the recommendations, noting that it will evolve in response to engagement with families and staff. The Executive Director of Nursing is accountable 		

	<p>for the improvement plan and the Service Director and Service Nurse Director are responsible for the implementation of the plan and changes to the service. Delivery against the action plan will be scrutinised by Quality and Safety Committee, who will keep the Board updated.</p> <ul style="list-style-type: none">• ENDORSE the Chief Executive discussing with executive leads for quality further improvements to the Health Board's quality system to develop and learn from this review and set out actions for the Health Board in quarter four of 2021/22.• APPROVE a report to be submitted to the Board in 6 months on progress of implementing the improvement plan and changes to the service; and• APPROVE the external reviewers, in 12 months' time, to review the actions taken, assess how these actions have improved the service and whether any further actions are required.
--	--

External Review of the Children's Community Nursing Team Service

1. INTRODUCTION

In the autumn of 2020 the Executive team commissioned an external review of the Children's Community Nursing Team Service. The review was commissioned in response to concerns raised by families who used the service. The review was undertaken by two external reviewers who were commissioned for their experience in providing social care services for families with children and long term commissioning.

The focus of the review was on identifying key areas of strength to build on, and areas of potential risk, where further action might be recommended. The review focused in more detail on:

- the culture of care, particularly focussing on family involvement;
- direct experience of children and families using the service;
- direct engagement with staff within the service; and
- how professional nursing standards are delivered.

2. BACKGROUND

The Children's Community Nursing Service team are one of the teams at the forefront of caring for children and young people with complex needs and providing the required level of support for this cohort of families.

Across Wales these teams have evolved in various ways over the past 20 years, some from within District Nursing Services and also Continuing Care monies, to become the mainstay of complex care in the community for children and young people.

3. BOARD OVERSIGHT

The Board and its Quality and Safety Committee have received regular updates on the issues related to the review and it is proposed that the Board approve the Quality & Safety Committee to oversee the implementation of the action plan.

4. SUPPORTING THE FAMILIES AFFECTED

A core objective when commissioning the review was to be open and transparent with the families using the service. The draft Terms of Reference of the review was shared with the families for their comment and they were invited to share their experience with the reviewers and many did.

Contact has been made with the families and arrangements are being made to share the Executive Summary and Recommendations section of the report with them. The external reviewers have agreed to attend the feedback sessions and the families will play an important part in terms of helping the Health Board to further develop the action

plan to a final version. Engaging with the family going forward is a key priority to build on the trust and the relationship.

5. SUMMARY OF FINDINGS OF THE REVIEW

The service is essential for families caring for a child with complex health needs. The reviewers spoke to families and dedicated skilled nurses and support workers, most with many years' experience. However, limitations were identified that prevented families from receiving the standard of service that would have been expected or which fully represented the Health Board values.

The Executive Summary of the report is attached as **Appendix 1**. In summary, there were several key factors which were identified as leading the CCN team being unable to fully deliver to the Health Board standards and values:

- ***The lack of clear governance team structures***; these were ambiguous and did not support easy oversight or the ability to identify concerning trends arising, to address issues in a timely manner, or to support decisions made. It was not possible to see how the Board could be assured as to the standards or safety of the service provided. There was also an accepted practice of incidents not being reported (via Datix) which also served to conceal emerging trends from the wider Health Board. Some immediate issues were identified at the time of the review and were addressed at the time they were raised.
- ***The service model***; whilst this provided services for three distinct categories of children (acute, chronic and Continuing Care), Continuing Care was the primary focus and formed the basis of funded establishment for the whole service. There were concerns about key management data being captured, and its use to support the service as a whole was limited. Service design itself had built-in challenges including the time taken to deliver an approved package of care, registered nurses working office hours whilst HCSW work mostly at night, and meeting a child's needs in a family home which was also the workplace for the HCSW.
- ***Partnership working***; The 'what matters to me' and 'voice and control' requirements that underpin the Social Services and Well-being (Wales) Act (2014) do not appear to have been reflected in the way services have been developed and offered to parents. There was little evidence to show families were partners in the delivery of care. Parents were found to be frustrated due to poor communication and relationship management from the leaders of the CCN Service, leading to a breakdown in the parent / service provider relationship. There was a perception of sanctions being imposed by the service should families complain leading to a lack of trust and / or total breakdown in the relationship with the team.

- ***Culture of care;*** This was identified as being complex with what appeared to be an inflexible leadership style. Staff were left feeling demoralised and frustrated having raised concerns relating to workload and their ability to sustain a safe service during the pandemic. No evidence was found to reassure the Board that concerns were appropriately addressed or resolved. The review highlighted that any continuing care decisions for paediatric cases were made by the adult panel who had limited knowledge to support decision making in such cases. There also appeared to be a lack of knowledge and understanding of the Continuing Care process within the wider HB management and governance arrangements, which reduced the ability to audit and monitor the implementation of the WG guidance to provide adequate assurance to the Board
- ***The experience of children and families;*** None of the families were critical of the CCN Service as a whole and many praised aspects of the service but there were concerns about specific issues which were not appropriately addressed. A recurrent theme included the Continuing Care assessment process. Many families spoke positively about the HCSWs that actually deliver the care and of Registered Nurses who helped and supported them to navigate the process to access care.
- ***The views of the CCN Team;*** In analysing the views and responses from all Registered Nurses in the team and a cross-section of HCSWs, it was clear staff were aware of the challenges and issues faced by the families and were keen to help resolve them. The review team felt the staff they met were caring and committed with innovative ideas that could help shape the team moving forward.

6. EXTERNAL REVIEW RECOMMENDATIONS & IMPROVEMENT ACTIONS

The reviewers identified that the actions taken by the Health Board prior to and during the review had been received positively by the families, and many families spoke of a significant improvement in both communication and service delivery.

Listening and engaging with families is key going forward to develop the service model so that it reflects what families need and want rather than expecting them to fit in to 'what we offer'.

The report contained 34 recommendations filtered into five themes:

- Assurance;
- Compliance;
- Service Development;
- Partnership and Engagement; and;
- Strategic Planning

The recommendations of the report are set out in **Appendix 2**.

An improvement plan has been developed, **Appendix 3**, which will evolve as the Health Board engages with families and staff. It is important that both the families and staff identify and engage with the action plan and feel confident that the actions will improve the service and build on the actions already taken prior to the commissioning of the external review.

The Quality & Safety Committee, on behalf of the Board will oversee the assurance and implementation of the improvement plan and receive a quarterly report to include feedback from families on the service. The Executive Director of Nursing is accountable for the delivery of the plan and the Directors of the Singleton & NPT Service Group (Service Group Nurse Director and Service Director) are responsible for implementing the actions and changes to the service. Furthermore, the external reviewers will be requested to consider the Health Boards response and action taken in 12 months to provide assurance to the Board.

7. RECOMMENDATION

- **CONSIDER** the findings of the report and implications of the quality of the service in the Health Board.
- **APPROVE** the action plan in response to the recommendations, noting that it will evolve in response to engagement with families and staff. The Executive Director of Nursing is accountable for the improvement plan and the Service Director and Service Nurse Director are responsible for the implementation of the plan and changes to the service. Delivery against the action plan will be scrutinised by Quality and Safety Committee, who will keep the Board updated.
- **ENDORSE** the Chief Executive discussing with executive leads for quality further improvements to the Health Boards quality system to develop and learn from this review and set out actions for the Health Board in quarter four of 2021/22.
- **APPROVE** a report to be submitted to the Board in 6 months on progress of implementing the improvement plan and changes to the service; and
- **APPROVE** the external reviewers, in 12 months' time, to review the actions taken, assess how these actions have improved the service and whether any further actions are required.

Governance and Assurance		
Link to Enabling Objectives <i>(please choose)</i>	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	<input checked="" type="checkbox"/>
	Co-Production and Health Literacy	<input type="checkbox"/>
	Digitally Enabled Health and Wellbeing	<input type="checkbox"/>
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	<input type="checkbox"/>
	Partnerships for Care	<input checked="" type="checkbox"/>
	Excellent Staff	<input type="checkbox"/>
	Digitally Enabled Care	<input type="checkbox"/>
	Outstanding Research, Innovation, Education and Learning	<input type="checkbox"/>
Health and Care Standards		
<i>(please choose)</i>	Staying Healthy	<input type="checkbox"/>
	Safe Care	<input checked="" type="checkbox"/>
	Effective Care	<input type="checkbox"/>
	Dignified Care	<input type="checkbox"/>
	Timely Care	<input type="checkbox"/>
	Individual Care	<input checked="" type="checkbox"/>
	Staff and Resources	<input type="checkbox"/>
Quality, Safety and Patient Experience		
The Improvement plan set out in Appendix 3 will improve the quality and safety of the service and the experience of care provided.		
Financial Implications		
There are financial implications in terms of implement the improvement plan.		
Legal Implications (including equality and diversity assessment)		
Staffing Implications		
Staff are being supported by senior managers to engage in the plans to improve the service.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The ' <i>what matters to me</i> ' and ' <i>voice and control</i> ' requirements that underpin the <i>Social Services and Well-being (Wales) Act (2015)</i> do not appear to have been reflected in the way services have been developed and offered. The improvement plan has been developed to comply with this Act.		
Report History	The Quality & Safety Committee and Board have been kept up to date of the developments of the external review.	
Appendices	Appendix 1: Executive Summary Appendix 2: Recommendations Appendix 3: Improvement plan	