

Northern Lincolnshire and Goole NHS Foundation Trust

RJL

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 13, 14, 15 October 2015
Date of publication: 15/04/2016

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)
RJLX2	Monarch House		
RJL32	Scunthorpe General Hospital		

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service **Good**

We found community health services for children, young people and families to be 'good' overall. Effective, caring, responsive and well-led were rated as 'good'. Safe was rated as 'requires improvement'.

- Care and treatment was evidence based and staff were competent. The organisation had implemented evidence based programmes, such as the family nurse partnership programme. There were policies and procedures in place to support staff and these could easily be accessed.
- There was good evidence of multidisciplinary and multi-agency working across the services.
- Staff were motivated and focused on providing high quality care with positive comments given by the patients we spoke with. Services were planned and delivered to meet the needs of the local population in line with the commissioning framework of the organisation.

- There were support networks in place to ensure children and young people were protected and Staff worked hard to meet the needs of children and families in vulnerable circumstances.
- The senior management team were clear on the vision to provide a collaborative approach to working across the whole trust. Managers were visible and accessible and there was a focus on seeking the views of service users.

However, we rated the safe domain as 'requires improvement' because:

- Many staff were not aware of learning or feedback from incidents.
- There was a lack of evidence that an acuity tool was used to allocate caseloads to health visitors, and staff were not aware that there was not a designated doctor for the looked after children's team.
- Three-monthly safeguarding supervision had not been taking place for health visitors, which did not meet national guidance published in March 2014.

Summary of findings

Background to the service

Information about the service

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

Children and young people under the age of 20 made up 23.2% of the population in North Lincolnshire and 11.2% of school children were from a minority ethnic group. The health and well-being of children in North Lincolnshire was mixed compared with the England average. Infant and child mortality rates were similar to the England average. The level of child poverty was worse than the

England average with 19.8% of children under the age of 16 living in poverty. The rate of family homelessness is better than the England average. Childhood obesity levels are in line with the England average; 9.7% of children aged 4-5 years and 20.7% of children aged 10-11 years.

We visited 12 locations across the North Lincolnshire area. We attended baby clinics, health visitor bases, a special school, the looked after children's team, a multi-disciplinary allocation meeting and, with parents' permission, went on four home visits.

We spoke with 61 members of staff including, senior managers and team leaders, health visitors, therapists, specialist nurses, administration and support staff.

The service had moved to electronic records, we were shown how information was inputted and stored on the system and reviewed nine electronic records.

Our inspection team

Our inspection team was led by:

Chair: Jan Filochowski, Clinical and Professional Adviser, Care Quality Commission; retired CEO of Great Ormond Street hospital.

Team Leader: Amanda Stanford, Head of Hospital Inspection, Care Quality Commission.

The team included CQC inspectors and inspection managers, and a variety of specialists: Senior nurses, doctors, allied health professionals, health visitor, a community Paediatrician, a school nurse, a safeguarding nurse, a pharmacist and an Expert by Experience who had been a carer of someone using services.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held about the service and asked other organisations to

Summary of findings

share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 13 to 15 October 2015

We observed how people were being cared for and talked with patients and family members who shared their views

and experiences of the care they had received. We reviewed care and treatment records of children and young people who used the services. We visited services based at Ashby Clinic, Barton Children's Centre, St. Hugh's School, The Willows Care Home, Parkwood Children's Centre, Early Learning Development Centre at Ashby Link, Crowle Community Hub, Brigg Children's Centre, Barnard Court, Monarch House and Scawby House.

What people who use the provider say

Patients gave positive feedback and said they felt involved in their care and treatment. Mothers in particular felt well supported and able to ask questions if they were worried about something.

Friends and Family Test (FFT) data from September 2015 indicated that, from the 185 responses, 99% would

recommend the service. In September 2015 a patient's satisfaction survey from the children's therapy group results showed 100% of respondents were satisfied with the overall service provided. There were 300 questionnaires distributed and 110 people responded, mostly completed by parents.

Areas for improvement

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

- The trust **MUST** ensure three-monthly safeguarding supervision takes place for health visitors.

- The trust **MUST** ensure staff can access and receive feedback and learning from incidents.
- The trust **SHOULD** ensure consistency with the role of the health visitor link to GP practices.

Northern Lincolnshire and Goole NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as 'requires improvement' because:

- There was a lack of robust systems to feedback learning from incidents to all staff. Incidents were not a standing item on monthly team meetings, which reduced learning opportunities. The national health visiting service specification 2014/2015, in place since March 2014, stated that health visitors must have safeguarding supervision every three months. This supervision was not happening.
- Staff we spoke with did not know the process and tools used to allocate caseloads to the health visiting teams and the number of complex cases for each health visitor varied.
- There were staffing concerns within therapy services highlighted on the community risk register.

- During our inspection we were told the looked after children's team did not have a designated doctor. Information provided to us following the inspection demonstrated there was a clinical lead for looked after children, however not all staff were aware of this.

However:

- Mandatory training attendance figures were good and staff knew and followed the policy for lone working.
- Staff in the Family Nurse Partnership (FNP) had monthly safeguarding supervision, which included female genital mutilation and child sexual exploitation.

Detailed findings

Safety performance

Are services safe?

- There have been no never events within community children's and young person's services. Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken.
- Incidents were reported on the trust electronic reporting system (Datix). We were told information from incidents was fed back at team meetings.
- The national NHS staff survey 2014 showed that the organisation scored slightly lower (worse) than the national average for the percentage of staff reporting errors, near misses or incidents witnessed in the last month. The score was 87% with the national average being 90%; this information was not available specifically for children's and young people's services.

Incident reporting, learning and improvement

- We found there were systems in place for reporting incidents. Throughout the services we visited staff told us the process for reporting incidents. From speaking with staff, feedback regarding incidents was variable amongst the different teams.
- Between October 2014 and October 2015 there had been 53 incidents within community children's services. 4% (2) of these were graded as moderate, 72% (38) were graded as low and 24% (13) were graded as very low.
- Ten of these incidents related to information governance and System One, the electronic records system used. The action plans from these incidents were clear with ways of preventing similar problems identified. System One was also a standing item on monthly staff meetings.
- We were told feedback from incidents can be seen on the 'hub' via the trust intranet but staff told us these are usually hospital based incidents. Incidents were discussed at monthly governance meeting attended by managers and we reviewed minutes of these. A newsletter 'lessons learnt' was also used to cascade learning from incidents as well as monthly professional meetings. We reviewed minutes of several meeting from different staff groups, therapists, health visitors and the whole team meetings; incidents were not a standing item for any of these meetings. Some staff told us attending meetings can be difficult. From speaking with staff we were not assured learning and feedback from incidents was consistent across all the teams.
- We found the trust had four action plans following serious case reviews. A serious case review (SCR) takes

place after a child dies or is seriously injured and abuse or neglect is thought to be involved. The review looked at recommendations and actions with an identified lead and a time scale. We saw that the actions were being monitored to ensure they were met. An example of this was assessment of mental health well-being at people's homes and the importance of how to complete this assessment without other people present. Domestic violence was to be included in safeguarding supervision and the domestic abuse policy was updated.

Safeguarding

- The organisation had policies and procedures for safeguarding and staff could describe how safeguarding referrals were made and gave us examples of when they have had to do this. Staff knew who to contact for advice and told us they would speak to the children's safeguarding team or their line manager. There were named nurses for safeguarding.
- We also looked at flow charts which clearly directed therapy staff if they had a safeguarding concern.
- Trust wide figures for children's safeguarding were 90% in July 2015 this was slightly lower than the trust's threshold of 95%. However, the health visiting service had achieved 100% compliance for safeguarding level three in July 2015.
- A 'flagging' system was used on system one to identify any children with safeguarding alerts. The electronic records we saw evidenced safeguarding policies being followed and liaison with other agencies such as social services.
- Safeguarding supervision for the staff within the Family Nurse Partnership (FNP) has a robust system of monthly supervision in place. Child sexual exploitation and female genital mutilation were also explored in relation to policies and procedures.
- Staff from the FNP team had all completed level three safeguarding training and level four accredited training.
- The National Health Visiting Service Specification 2014/2015 which was published in March 2014 states health visitors must receive a minimum of three-monthly safeguarding supervision of their work with their most vulnerable children and babies. This must be done by a colleague with expert knowledge. Staff told us this was currently taking place six monthly. Within the health visiting teams three-monthly safeguarding supervision had not been taking place, managers were aware of the guidelines and told us there had not been the capacity

Are services safe?

to provide the relevant training. We were told by the senior management team this had now been addressed and three-monthly supervision would now be commenced.

- Staff told us information relating to safeguarding was easily accessible and we were shown folders where this information was stored.
- The safeguarding team were accessible and staff were able to provide examples of when they had contacted them for advice.
- The Looked After Children's (LAC) team had an office next door to the safeguarding team so had a close working relationship. They told us a weekly notifications list was produced and about the various systems in place to track and trace LAC.
- Staff told us Female Genital Mutilation (FGM) is covered within their safeguarding training and there was a pathway for staff to follow. We reviewed the policy which gave clear definitions and reporting procedures.

Medicines

- We were provided with a list of health visitors and FNP staff who were independent prescribers. This enabled timely access to medicine and treatment.
- The pharmacy department within the hospital could be contacted for support if required.

Environment and equipment

- We checked equipment for evidence of portable appliance testing (PAT), this is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. We looked at equipment in the areas we visited and all had in date PAT.
- Therapy staff told us the process for borrowing equipment from the equipment store and the process of applying through the monthly panel meetings for other equipment. Occupational and physiotherapy staff told us equipment requests for children were usually approved, and when it needed replacing, for example as the child grows, further panel approval was not required.
- Health visitors each had a set of scales which they took on home visits and used in baby clinics. We saw evidence of weighing scales and carbon monoxide analysers being calibrated.

- We reviewed the community equipment service protocols for maintaining equipment. From speaking with therapy staff we were not assured that systems were in place to maintain equipment once in schools or at people's homes.
- The risk register highlighted that the medical devices agency advised actuators, a type of motor which is responsible for moving or controlling a mechanism on hoists, should be replaced every five years. Many of the hoists were 15 years old, this was currently with the commissioners to provide a plan, in the interim we were informed six monthly load testing was being done.
- We visited a number of locations where teams were based and clinics were held. They were all well maintained and suitable environments for families and children. We reviewed 18 departmental review tools which included an audit of the environment. These audits had highlighted some issues, for example dust at high levels and seals around sinks needing replacing. Action plans with dates for completion were included within the audit tool.
- The premises for the Child Development Centre (CDC) were being refurbished, they were temporarily located in children's centres but delays in the refurbishment meant they would have to relocate again. This is highlighted as a risk on the community risk register as the completion date for refurbishment was unknown and the team members within the CDC could not all be accommodated in one temporary location.

Quality of records

- We reviewed a sample of health records within community children's services and found they were detailed and fully completed. We were told records were peer reviewed and audited monthly and this information was shared at professional meetings to identify any gaps or areas for improvement. From the minutes we reviewed we could see no evidence of this.
- We reviewed a documentation audit which had taken place in 2014/2015 with the results published in May 2015. This was an audit of over 650 patient records both electronic and paper, for community and therapy services. The audit was done against ten standards and the results were per team. The results were RAG rated (red, amber, green) there were some identified areas for improvement but no red rated areas within community

Are services safe?

children's services. Red was identified when the records reviewed had 69% or less completed for a standard e.g. the clinical record contains discharge/ transfer information.

- System one was the electronic system used for record keeping. Speech and language therapy staff were still using paper records, we saw that these were stored securely in locked metal filing cabinets. Documents such as early help assessments had to be scanned into system one as there was no facility to input directly in to the electronic system.
- Staff told us there could be repetition of work and inputting data on to system one could be time consuming, for example, some meeting minutes had to be typed up, printed then scanned in to system one. Staff did tell us they had only recently being given laptops to work with and there was ongoing work with system one. Some areas had system one champions and dedicated time had been given to a health visitor with an interest in information technology to try and improve systems and processes.
- Within the FNP they were not able to share records on system one. The FNP cover North Lincolnshire and the North East, families in the Goole area have generic system one records so universal health visiting teams can access system one records. Families in North Lincolnshire are not on the same unit as FNP on system one therefore records are not transferable. This situation had been escalated but was not seen to be a concern so not further action had been taken. It does not adhere to the national health visiting service specification march 2014, which states 'providers will ensure that all staff have access to sharing information to safeguard or protect children'.
- The LAC team could access system one to look at attendances in the accident and emergency department, children's immunisation status and hospital records if needed. This meant if they had concerns they could access further information relating to a child.
- We observed home visits being recorded electronically immediately after the visit this was done by scanning a hand written proforma into the system.
- Information was seen recorded in parents 'red books' whilst attending the baby clinic however during the five baby clinics we visited nothing was recorded 'live' in system one. Information was written on a clinic

attendance sheet. Health visitors told us they did not like completing records electronically in clinics or people's homes. Some staff said they felt it was a barrier to communication.

- We observed a discussion between a parent and health visitor relating to a nut allergy, had system one been accessed during the clinic information and history relating to this would have been available.
- We raised a concern about records from system one being printed out for a multi-disciplinary team meeting then collected in for shredding at the end of the meeting. This was due to some members of the team not having access to system one records. This was raised with the management team at the time of inspection; they were not aware of this practice but said they would take immediate action to stop this practice as there was a risk of confidential information being accessed.
- Electronic records could be accessed remotely by the use of laptops, these could only be accessed by use of a smart card. We were told getting internet access could be an issue when working outside of the office depending on the location, staff said this had improved with the use of laptops. System one was a standing item on all of the meeting minutes we reviewed.

Cleanliness, infection control and hygiene

- There were policies and procedures for infection control and prevention; these could be accessed on the intranet. Infection prevention training formed part of staff's annual mandatory training. Information provided by the trust showed the target of 95% was not being met for infection prevention training for community staff, it was 91%. This data was for all community staff not specifically those employed within children's services.
- The children's centres, clinics and health visitor bases we visited were all visibly clean. Hand washing facilities, alcohol gel and personal protective equipment was available.
- We observed staff using alcohol gel to clean their hands between patients and staff were bare below the elbows.
- In baby clinics equipment was cleaned with wipes between each patient as well as applying a new piece of paper roll.
- We reviewed 18 department review tools which included hand hygiene facilities. They were from a range of areas including children's centres and health visitor bases. Each scored between 80% and 100% for hand hygiene

Are services safe?

facilities being available. A direct observation of hand hygiene was not included in the tool, however an annual hand hygiene competency audit was completed with action plans developed if completed numbers were less than 100%. This data was collated within a RAG rated dashboard which we reviewed.

Mandatory training

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

Assessing and responding to patient risk

- Staff told us risk assessment was part of their role and was included in their standard documentation used on system one. From the records we reviewed there was evidence of risk assessments being completed.
- There were pathways in place for staff to follow in response to risk, for example parents failing to attend for an appointment or children not being present at home visits. We reviewed the pathway for perinatal mental health and discussed this at the management meeting. It contained contradictory information in the introduction and on the actual pathway with regard to the time frame in which perinatal mental health would be assessed. We were told this would be addressed.
- Staff told us about situations where they would not be happy to conduct home visits alone. This information was stored electronically so it would alert any other staff to ensure they were accompanied.
- At a special school we visited they had access to medication if a child was fitting. In any other emergency situation either within a clinic or a person home, staff would dial 999.
- The working together to safeguard children document published in March 2015 states the roles and responsibilities in relation to children's safeguarding and the requirement to have a designated doctor who takes a strategic lead. During our inspection we were

told that the LAC team had no designated doctor or medical strategic lead for the service. Information provided by the trust following the inspection demonstrated there was a clinical lead for the LAC team. This information had not been communicated to the staff at the time of inspection.

Staffing levels and caseload

- We reviewed data on caseloads for therapy staff (physiotherapy, occupational therapy and speech and language therapy) numbers varied from two to 114. There was 1.6 whole time equivalent (WTE) physiotherapy cover for the area. We were told current caseload was approximately 180 children. This was on the risk register as a moderate risk, a business case to increase the establishment had been unsuccessful so an action of developing joint pathways to work more efficiently was recommended.
- Speech and language therapist were also a moderate risk on the community risk register as there was a reduction in staffing due to recruitment issues. This was a risk as there was potential for the service to be reduced.
- Lord Laming's report in 2009 on the protection of children in England stated that health visitor caseloads should be no more than 300 families or 400 children. We were told by the management team caseloads for each health visitor were between 300 and 350, meaning the recommendations were being achieved. We saw evidence of a spreadsheet which supported this. We were told weekly management meetings took place to review caseloads as the pressure of them could vary. We were not assured that an acuity tool was being used to look at caseload weighting. Staff told us caseload allocation was a challenge due to the large geographical area and the differences in levels of deprivation and this information helped determine caseload allocation. Staff told us they were not sure exactly how this was done, but that it was done on an individual team basis with no formal process. Other staff told us it was decided at management level and if a health visitor was struggling with their caseload it would be discussed at a team meeting to see if any families could be reallocated. The number complex cases allocated to a health visitor was variable amongst the staff we spoke with, some had five other had up to 22.

Are services safe?

- Information provided by the trust showed that the percentage turnover of staff within health visiting varied from team to team and was between 0% and 29.66%.
- The FNP team was led by one WTE supervisor and had three WTE family nurses in North Lincolnshire. The team had a quality support officer. We were told their current caseload was 21 this was less than the national maximum recommendation of 25.

Managing anticipated risks

- The organisation had a lone worker policy. Staff we spoke with were aware of the policy. Staff showed the

inspection team their lone worker devices and we observed the procedures being followed on the home visits we attended. Staff updated their electronic diaries so colleagues know where they were.

- Staff told us they would use risk assessments for first visits and 'buddy up' if they had any concerns, risks were communicated via system one.
- Staff told us other venues would be used to see families where the home risks were assessed as high.

Major incident awareness and training

- Staff told us during adverse weather conditions they would prioritise their workload, or may work from home and contact families by telephone if it was deemed too dangerous to travel.

Are services effective?

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

Summary

We rated effective as 'good' because:

- Care was evidence based and staff could access policies and guidelines easily because the trust provided them each with a laptop.
- National initiatives such as the healthy child programme were followed.
- There were good support systems for women who chose to breastfeed. Various services and initiatives were used to support breastfeeding and audits were conducted to identify areas for improvement.
- We saw evidence of effective multi-disciplinary working to meet the needs of children and young people in all of the areas we visited. The Family Nurse Partnership had robust measurement and monitoring of patient outcomes.

However:

- Therapy outcome measures were not always recorded and it was identified work needed to be done to improve this.

Detailed findings

Evidence based care and treatment

- Children's and young people's needs were assessed and treatment was delivered in line with current legislation, standards and evidence-based guidance. Policies were available on the trusts intranet and staff could access them quickly because they each had their own laptop. We were told the educational lead took responsibility for keeping these up to date.
- UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breastfeeding and promote parent/infant relationships. The health visiting service was currently accredited to stage two, which meant the service had demonstrated assessment of staffs knowledge and skills. Staff told us they attended training on this.
- We reviewed a trust audit on UNICEF baby friendly initiative from July 2015. The audit identified areas for

improvement, for example of the 20 people interviewed on 60% had adequate knowledge on how to attach the baby to the breast, so this was identified as an area for improvement.

- The trust had a FNP team. This is a voluntary health visiting programme for first-time mothers. This is a voluntary preventative programme offering intensive and structured home visits by specially trained nurses.
- The healthy child programme (HCP) is the main universal health service for improving the health and well-being of children. This is done through health and development reviews, health promotion, parenting support and screening and immunisation programmes. The health visitors and FNP followed this initiative and delivered it to the 0-19 age range.
- Health visitors and the FNP used Ages and Stages Questionnaire's (ASQs) as part of their assessment of children. This is an evidence based tool to identify a child's developmental progress, readiness for school and provide support to parents in areas of need.

Nutrition and hydration

- There were breastfeeding support groups across the North Lincolnshire area. BABES was a support service funded by the local authority, they visited breastfeeding mums at home within 48 hours as well as providing telephone support. A breastfeeding co-ordinator who was based at the hospital was also available for advice.
- A breast feeding café was available in one of the clinics.
- We observed health visitors giving parents advice on breastfeeding and weaning. We observed a conversation over a baby with feeding problems, mothers said they felt supported in this area.

Technology and telemedicine

- Staff showed the inspection team laptops that had been recently issued. This enabled staff to have more access to the network when working outside of the office. Several staff told us connecting to the network could be an issue depending on their location.

Patient outcomes

Are services effective?

- Data reviewed from March 2014 to April 2015 showed that 100% of women received new birth visits from health visitors, 80% to 94% of these visits were within 10-14 days of birth. There is no comparable data for these figures.
- A higher percentage of children in care are up to date with their immunisations in comparison to the England average for this group.
- FNP outcomes were robustly measured and monitored through the 'Open Exeter' information system. The supervisors update for September for the 2015 FNP board demonstrated the stretch goals of achieving 60% of clients enrolled before 16 weeks currently stands at 64%. 100% of mothers enrolled on the programme are first time mothers who meet the designated criteria. The stretch target of clients achieving 80% or more expected visits during Pregnancy was 83%.
- Breastfeeding initiation rates were 51%, this was worse than the England average which is 73.9%. Those mothers still breastfeeding at six months drops to 6%.
- Therapy Outcome Measures (TOM) are a way of measuring children's health needs at the start of their patient journey, working with them and their family to meet these health needs, then evaluating to hopefully demonstrate an improvement. We were told TOM's were a working progress, they were part of the allied health professional specification and key to achieving them was patient pathways. We reviewed the minutes of a whole team meeting in March which stated the completion of TOMs had significantly increased from 7% to 42%, it was minuted that it was hoped to increase this to 80-90% to clearly demonstrate what the service is achieving to commissioners. Meeting minutes from September stated TOM's were to be discussed at audit sessions with discussion to be on why more forms are not completed and ways to complete forms for more complex patients.
- We were told one day a week was being dedicated to recording and reporting data on system one by a staff member with a particular interest in this.
- We were told the key performance indicators (KPI's) for the CDC were not being met due to the building being refurbished and a lack of a clinical psychologist in post. This post had been recruited to and had a start date in November.
- All staff new to the organisation attended a corporate induction as well as a local induction.
- We saw a competency assessment for therapy assistants.
- Newly qualified staff completed a preceptorship package. We spoke with staff members who were in the process of completing this and felt it was a good tool which helped support their learning.
- There were formal processes in place to ensure staff received training and an annual appraisal. Staff told us they received formal and informal supervision, however this was not three-monthly for health visitors, which did not meet national guidance published in March 2014
- All the staff we spoke with said they had received their annual appraisal. Figures provided by the trust showed 90-93% of community staff had undergone appraisal for 2014/2015.
- Senior management told us a business case review will be done cross-site looking at staffs skills to maximise output and provide a better service.
- Staff told us they have been able to access further training, for example in new-born observation and assessment and perinatal mental health.
- Many of the staff were very experienced in their role and said they supported the more junior staff if a situation arose they were unsure of how to manage.
- The LAC team told us they have discussions with newly qualified social workers so they can outline their role.
- The FNP told us they have monthly psychological supervision and have received training looking at models of supervision.

Multi-disciplinary working and coordinated care pathways

- We were provided with and observed a range of evidence which demonstrated how services worked together and with other agencies to meet the needs of children and young people. For example we observed a multi-disciplinary allocation meeting.
- We were told all children with complex needs had a named health visitor, and a complex needs nurse is part of the community team based at the hospital in Scunthorpe.
- We observed staff working collaboratively with parents and other agencies to provide care and support for families.

Competent staff

Are services effective?

- Health visiting and the LAC team had close links with safeguarding and system one was an effective tool for sharing information between the hospital and community.
- We observed good working relationships between therapy and health visiting staff and paediatric consultants who were based at the hospital but spent 70% of their time within community settings.
- Each GP surgery had a named linked health visitor. The different teams we visited all had different arrangements and expectations for liaison with the practice managers and GP's. We were provided with a draft standard operating policy for GP and health visitor links but the staff we spoke with were not aware of this.
- We were told all GP's are notified of mothers entering the FNP programme by letter.

Referral, transfer, discharge and transition

- We saw pathways for referral to the CDC and were told about the process for referral, we observed this within a multi-disciplinary allocation meeting we attended.
- We reviewed the midwife/health visitor liaison pathway.
- The LAC team have links with social workers if children are placed out of area. They also have links with sexual health and virgin care. System one is used as a flagging system and the team communicate with the accident and emergency department and the drug and alcohol misuse team.
- The FNP team told us they work closely with midwifery services, they often get notified of teenage pregnancies or vulnerable persons from a variety of sources, for example, school nurses, head teachers, probation services. They would however wait for a formal referral.
- There were policies in place for children who left the area and staff could tell us the process if a child moved out of or in to the area to ensure continuity of care.

- Evidence of handover from midwives and school nurses was seen in the electronic records we reviewed.
- Transitional services within community children's nursing teams had nurse-led and consultant-led clinics. We were told transition begins early and they have access to transitional clinics in Sheffield. They work closely with educational services to support those with a disability who have to leave the service aged 18.

Access to information

- Staff we spoke with were able to access information relating to the children and families they were caring for. We observed electronic and paper systems to manage patient records.
- All staff could access the trust intranet which contained links to current policies and guidelines.
- Information was available on who to contact in particular situations, for example the safeguarding team and how they could be contacted.

Consent

- The trust had a consent policy which included specific references to children and young people. Staff told us they have a robust consent policy which they adhere to.
- We observed staff gaining consent prior to a home visit.
- Staff told us they took the opinions of children and young people in to account when obtaining consent. They were aware of and the used the Gillick competencies for consent of patients under the age of 16.
- We reviewed information in parents red book relating to the handling of information.
- We reviewed additional information for therapy staff on getting consent. Staff could articulate a good understanding of their responsibilities and would seek consent before commencing treatment.

Are services caring?

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

Summary

We rated caring as 'good' because:

- Patients gave positive feedback and said they felt involved in their care and treatment. Mothers in particular felt well supported and able to ask questions if they were worried about something.
- There was a focus on the importance of perinatal mental health.
- Staff were compassionate and caring and motivated to provide high standards of care.

Detailed findings

Compassionate care

- To assist us in understanding people's experiences of the service we spoke with 14 people who used children's services. As part of our inspection we observed care in people's homes, clinic settings and observed staff speaking to clients on the telephone. In all these areas staff were kind, empathetic and took time to listen to parents concerns. We observed one health visitor arranging another home visit the following day to support a parent who was struggling with breastfeeding.
- All the staff we spoke with were passionate about their roles and were committed to delivering a quality service.
- The feedback we got from speaking to parents was very positive with regards to the care they and their child received. One parent said the health visiting team were very supportive and informative. Parents at the baby clinics said staff were welcoming and friendly. Parents told us they had confidence in the information provided to them.
- People were treated as individuals and we observed good working relationships between staff and parents.

Understanding and involvement of patients and those close to them

- Therapy staff we spoke with within a special school said they are meeting with parents to review the services they provide and get feedback.

- Staff within the special school we visited told us how they had used a photographic journey to inform a child of what would happen before they went in to hospital for an operation, this helped reduce their anxiety as they had seen pictures of each stage prior to their visit.
- Parents and carers felt involved in discussions about care and treatment options and that they felt confident to ask any questions. Families referred and seen by the CDC received a copy of the report and had a choice of who was the lead professional.
- The CDC told us they often provided information to parents then arranged a further visit to allow them time to absorb what had been said and then ask any questions.
- We reviewed Friends and Family Test (FFT) data from September 2015, from the 185 responses 99% would recommend the service.
- In September 2015 the children's therapy group presented the findings from a patient's satisfaction survey. 300 questionnaires were distributed with a response rate of 110. They were mostly completed by parents. A pictorial scoring system was used and the results showed 100% were satisfied with the overall service provided. Following the survey an action plan was written which aimed to develop a tool to capture the views of children and young people and set up an audit cycle.

Emotional support

- Children, young people and their families were cared for by the staff from the organisation. If further more expert support was needed, these services could be referred in to, for example counselling services.
- Staff in the baby clinics told us they had access to a room which was more private if they could see mothers were upset or wanted to discuss something on a one to one basis without other people being able to hear what was being said.
- There was a pathway for perinatal mental health and several staff spoke of how important this was.
- The staff from the LAC team had a particular focus on young people's emotional health and told us they had meetings every six weeks with the specialist LAC CAMHS team.

Are services responsive to people's needs?

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

Summary

We rated responsive as 'good' because:

- We observed a range of children's and young people's services working flexibly to meet the needs of their clients. For example a temporary outreach service was provided by the Child development centre (CDC) whilst building refurbishment was under way.
- We saw examples of meeting the needs of vulnerable people. The Family Nurse Partnership had looked at engagement with male family members and a health visiting team had formed good relationships with the traveller community.
- Communication with families and children was a focus for all the teams we visited and we were given examples of different ideas which had been developed to support meaningful communication.
- There had only been two formal complaints about the service from April 2014 to March 2015 which were successfully resolved.

Detailed findings

Planning and delivering services which meet people's needs

- Staff told us 'Big word' interpreting services are used for none English speaking families and could be accessed when needed.
- Due to the refurbishment of the CDC and its temporary location at the time of our inspection being less central, staff told us they had temporarily implemented an outreach service to stay in contact with families.
- The CDC also had an open referral pathway meaning GP's, health visitors, paediatricians, therapists or early years team could refer patients in.
- The speech and language therapy staff told us how they had developed 'communication bags' for individuals. They contained specific information, advice and strategies to support and individual. They remained with them at all times and the contents could be provided by parents, teachers or providers of children's services.
- Staff told us there was good engagement with children's centres and schools to undertake community engagement projects.

- The health visiting teams told us they had developed the system of having a daily 'duty worker' who was office based. They answered the telephone and dealt with day to day tasks meaning the rest of the team could focus on their caseload.
- The FNP 'hot desk' and mobile work out of different bases to meet the needs of their clients.
- The LAC team told us they try to be flexible with appointments to ensure attendance from young people. This is done by offering appointments after school hours or in school holidays. They also liaised with community dental clinics and made local arrangements for LAC to be seen up to the age of 21.

Equality and diversity

- 94% of community staff had completed equality and diversity training, this was slightly lower than the trust target of 95%. This information was for all community staff and not specific for those responsible for children and young people.
- One of the health visiting team we visited had formed good relationships with the traveller community and visited them weekly and had signed one family up for an early help assessment.
- The family nurse partnership have looked at their engagement with male members of families, and they told us that it has been successful. Staff told us their data for repeat pregnancies was 9-10 out of 122 which was lower than the national average.
- The staff we spoke with had an understanding of the ethnic and cultural needs of the clients on their caseload, they could describe what modifications could be made to meet their individual needs.

Meeting the needs of people in vulnerable circumstances

- We were told that 90% of mothers who fit the criteria for the family nurse partnership accept, if they decline an early help assessment is completed and tasked to the health visitor team via system one.
- The LAC team told us they were lower than the national average for placement changes. They would like to develop an additional role to support care leavers as they are a vulnerable group of people.

Are services responsive to people's needs?

- We spoke with one parent who was dealing with lots of family issues in addition to a new born baby, she said she could not have managed without the support of the health visiting team.

Access to the right care at the right time

- The LAC team told us they keep their target for reviews equal to or above 98%. When a health assessment is requested for a child who is out of the area it is completed within four weeks.
- We were told the specification for the designated doctor in the LAC team included a pathway for health assessments and medical assessment for adopted children.
- Staffing issues in paediatric occupational therapy due to long term sickness were on the community risk register as a moderate risk, as non-urgent referrals were waiting up to 37 weeks to be seen. We were told by occupational therapists that the waiting list had reduced with the introduction of a new pathway which involved children being screened before being formally assessed. We were told occupational therapy were working towards a four week waiting list. Data from August 2015 indicated referral waiting was over 11 weeks, and this had reduced to three weeks on October 2015.

- We were told the maximum wait time from referral to first contact with speech and language therapy (SALT) was 10 weeks. We were also told the use of dysphagia pathways meant a reduced time of three days to three weeks depending on the pathway used.
- The physiotherapy team were working toward a four week waiting list, we were told this was a challenge due to the number of physiotherapy staff but that currently they were achieving this, we reviewed data to support this. We were told the Calderdale framework was planned to be used to look at different ways of working.
- We were told children over the age of five who had a problem which was musculoskeletal only would be referred to the hospital team to help reduce the workload.

Learning from complaints and concerns

- The organisation had a complaints policy. Staff all told us they would try and resolve complaints at a local level to avoid escalation. Staff were aware of the duty of candour and the importance of being open and honest. Staff were aware of how to refer people to the patient and advice liaison service (PALS) if local resolution was unsuccessful.
- There have only been two formal complaints to the service between April 2014 and March 2015 which were both resolved successfully.

Are services well-led?

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

Summary

We rated well-led as 'good' because:

- The management team had a clear vision and plans for more collaborative working.
- The children's and young person's service knew about their risks, for example staffing, and they identified ways to address this.
- Staff spoke very positively about local leadership and the visibility of managers.
- Feedback was sought by individual teams from patients. The service had various communication strategies to encourage collaborative working.

However:

- There was still an element of staff feeling detached from the acute hospital sites.

Detailed findings

Service vision and strategy

- When we spoke to staff within the children's service, they were clear about the vision of their individual service. We reviewed the early help strategy and although staff did not refer to this document, staff spoke about the aims within it. For example, the health visiting and therapy teams spoke about the importance of working together with children and their families and ways of working more efficiently to improve outcomes with a particular focus on communication.
- The management team and staff members spoke about the development of patient pathways to improve services, for example perinatal mental health.
- Due to changes in commissioning of services for example, school nursing, was now commissioned by the local authority and the same planned for health visiting on the 1st of October 2015, it was difficult to outline a strategy at the time of our visit. Senior management that we spoke with had a vision of integrated working and equality of outcomes and had plans for more holistic care and outcome based interventions.
- We saw evidence on team bases of their objectives and goals and some staff could articulate these.

Governance, risk management and quality measurement

- The organisation provided evidence of the risks identified in children's and young people's services. Staffing, particularly relating to therapy staff was a concern, the trust was planning to use the Calderdale Framework to address this. The Calderdale Framework is a workforce development tool that reviews the skills and roles of staff in relation to service design. We reviewed plans for October 2015 in relation to this, looking at the role of band four assistant practitioners and spreadsheets looking at staff competencies.
- Staff were aware of risk management particularly in relation to lone working and we saw evidence of robust systems in place to manage this risk.
- There were systems in place to feedback information to staff via newsletters and emails. The minutes we reviewed from staff group meetings showed information relating to a number of issues was fed back, for example system one issues and clinical supervision. Risk management issues were discussed at monthly clinical governance meetings, although we were not assured that information from these meetings reached all staff members.
- We spoke with the management team, they told us they were aware of the issues relating to line management across community services particularly as such a large geographical area was covered. They told us the current management team was still relatively new and they felt they had taken steps to address this by clearly defining team structures and developing cross site and team working.

Leadership of this service

- Staff spoke positively about their line managers and the management of the services they worked for. Staff told us their line managers were easily accessible and visible. Staff told us managers were very approachable, so and they could seek support when required.

Are services well-led?

- Staff told us they were aware of who the senior management team are that there is are 'open door' events but these are often at the hospital sites, health visiting staff said senior management had been on a home visit with them.
- Within the health visiting teams many of them self-managed but they did see their line managers at least monthly.

Culture within this service

- Staff told us they have felt better supported than ever in the past six months, and that they felt valued in their role.
- Staff told us there had been some staffing problems which meant some reallocation of caseloads but they did not feel this had an impact on the service they provided.
- Staff told us they still did not feel integrated with the acute trust.

Public engagement

- Friends and family test was used within children and young person's services although staff told us they did not get any feedback from this.
- We saw and reviewed evidence from different staff groups in relation to engagement. For example we reviewed the questionnaire results of 84 people who had been involved in early help assessment. We also saw the children's therapy team service user involvement plan who were auditing their records to evidence the mechanisms in place.

- The LAC told us they engage with young people and use 'creative conversations' which has been set up by the children's care council.
- There was a wealth of information available in the children's centres and baby clinics, including health promotion and support services as well as activities for children and young people.
- Posters displayed in entrance areas included information in different languages.
- The backs of doors in toilets and private rooms were used for displaying information on more sensitive subjects such as domestic abuse.
- The FNP had a Facebook page for their clients to access.

Staff engagement

- Staff from all disciplines told us the park and ride system for the hospital was a barrier to them seeing clients there. Some community staff said they would not know where to go if they were going to work from the hospital site.

Innovation, improvement and sustainability

- Speech and language therapy staff used CALL, communicative aspects of learning and life. This is done via e-learning and is a way of developing verbal and non-verbal interaction and social skills for children and young people through implementation of the CALL resource.
- We reviewed a number of other resources and training the trust is implementing to improve communication between staff and children and young people, for example partnership working in schools and the encouraging learning skills programme.

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 18 HSCA (RA) Regulations 2014 Staffing

- How the regulation was not being met: The trust did not have suitable arrangements in place to ensure that persons employed for the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal.

The trust must:

- ensure there are suitable arrangements in place for health visitors to receive three-monthly safeguarding supervision. 18(2)(a)

Regulated activity

Treatment of disease, disorder or injury

Regulation

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

- How the regulation was not being met: The provider did not have suitable arrangements in place to do all that was reasonably practicable to mitigate identified risks.

The trust must:

- ensure staff can access and receive feedback and learning from incidents. 12(2)(b)