Good

Leicestershire Partnership NHS Trust

Community health services for children, young people and families

Quality Report

Trust Headquarters
Lakeside House
4 Smith Way
Grove Park
Enderby
Leicester
LE19 1SX
Tel:0116 225 6000
Website: www.leicspart.nhs.uk

Date of inspection visit: 9-13 March 2015
Date of publication: 10/07/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT596	**Melton Mowbray Hospital**		LE13 1SJ
RT5YG	**Loughborough Hospital**		LE11 5JY
RT5YF	**Hinckley and Bosworth Community Hospital**		LE10 3DA
RT5YC	**Ashby and District Hospital**		LE6 1DG

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

Summary of findings

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 Leicestershire Partnership NHS Trust and these are brought together to inform our overall judgement of Leicestershire Partnership NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Good

We rated this core service as good because:

- Incidents and near misses were reported and learning from these was shared.
- There were appropriate arrangements in place for the safe management of medicines. The “cold chain” processes to ensure optimal conditions during the transport, storage, and handling of vaccines was outstanding.
- Staff had the right qualifications, skills, knowledge and experience to do their job. They were supported to have training to help them to develop additional skills and expertise.
- Care and treatment of children and young people was planned and delivered in line with current evidence based guidance, standards and best practice. Consent to care and treatment was obtained in line with relevant guidance and legislation.
- There were good examples of collaborative team working and effective multi-disciplinary and multi-agency working to meet the needs of children and young people using the service.
- Feedback from those using the service was positive about how they were treated by staff and about how they were involved in making decisions with the support they needed.
- Services were planned and delivered in a way that met the needs of the local population, for example the Diana Service and the Family Nurse Partnership.

However:

- Waiting times for referral to initial assessment appointments were good, although patients experienced delays for community paediatric clinic follow up appointments.
- The school nursing service was understaffed and consequently there was an adverse impact on outcomes for children and young people and on staff morale. Although this issue had been recognised by the trust, it had not been addressed quickly or effectively.
- Some key outcomes for children, young people and families using the service were regularly below expectations. Outcomes of care and treatment were not always consistently or robustly monitored.
- The risks and issues described by staff did not always correspond to those reported to and understood by their leaders.
- Staff were positive about the support they received from their local leaders and managers but were less connected with senior leadership and management teams in the children, young people and families services.
- Staff did not always feel actively engaged or empowered. When staff raised concerns or ideas for improvement, they felt they were not always taken seriously.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

Summary

- We rated this service as good because children, young people and families were protected from harm.
- The systems in place for reporting and recording safety concerns, incidents and near misses were used effectively. Staff learnt from reported incidents.
- Appropriate safeguarding arrangements were in place and staff were aware of sources of advice if required.
- There were appropriate arrangements in place for the safe management of medicines and the prevention of infection. The processes followed to ensure the correct storage of vaccines were outstandingly good.
- There was no use of a dependency tool or other methodical assessment of workloads. This meant that workloads and the pressures on staff varied across the service.

Are services effective?

Good

Summary

We rated this service as good because children and families were receiving effective care, treatment and support.

- There was a clear focus on providing the best tailored service to the patients, as exemplified by neighbourhood forums which brought relevant professionals together to agree provision that best met the child's needs rather than family being referred from service to service.
- Staff had the right qualifications, skills, knowledge and experience to do their job. They were supported in gaining additional skills and expertise.
- Care and treatment of children and young people was planned and delivered in line with current evidence based guidance, standards and best practice. Consent to care and treatment was obtained in line with relevant guidance and legislation.
- There were examples of good team collaboration and effective multi-disciplinary and multi-agency working to understand and meet the range and complexity of the needs of children and young people using the service.

Are services caring?

Good

Summary

We rated this service as good because:

Summary of findings

- Children, young people and families were treated with compassion, kindness, dignity and respect.
- Feedback from those using the service was positive about how they were treated by staff and about how they were involved in making decisions with the support they needed.

Are services responsive to people's needs?

Good

Summary

We rated this service as good because:

- Services were planned and delivered to meet the needs of children and young people.
- Interpreters and a multi-lingual cultural link support worker provided effective support to practitioners who delivered care to patients and families whose first language was not English.
- However, waiting times could be very long for community paediatric follow up appointments.
- Target times for initial health assessments for looked after children were not being met.

Are services well-led?

Requires improvement

Summary

We rated this service as requires improvement because:

- Local leadership was well regarded by staff, as was the chief executive, however views were generally less positive about the services' other senior management.
- Staff were positive about the support they received from their local leaders and managers but were less connected with senior leadership and management teams in the children, young people and families services.
- Not all staff were aware of the services' vision and values.
- Staff perceptions of engagement and empowerment varied, with some feeling that their concerns or ideas for improvement were not taken into account.
- There were processes for obtaining the views of children, young people and families using the service.

Summary of findings

Information about the service

Services for children and young people had been brought together for the first time three years ago in the Families, Young People and Children division of the Leicestershire Partnership NHS Trust.

Community health services for children, young people and families were delivered by a team of over 500 staff with specialist skills. The trust delivered services for children and young people aged from birth up to 19 years of age, who are still in education. These services included:

- child development assessment,
- physiotherapy,
- occupational therapy,
- speech and language therapy,
- Family Nurse Partnership,
- health visitors
- school nurses.

The delivery of contraception and sexual health services was provided by another NHS trust from a neighbouring region. We did not inspect these services as part of the community health services for children, young people and families provided by Leicestershire Partnership NHS Trust.

During our inspection we spoke with 35 parents or carers, children and young people. We spoke with a range of staff, 82 in total, including health visitors, school nurses, nursery nurses, doctors, therapists, and administration staff. We observed clinics with community paediatricians and therapy staff. We accompanied health visitors on home visits.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting

The team that inpected this core service included a CQC inspector and a variety of specialists which included a health visitor, school nurse manager, children's lead for therapy services and a children's community services matron.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health 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?

Summary of findings

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the community health service for children, young people and families. We asked other organisations to share what they knew. We carried out an announced visit between 10 and 12 March 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, and therapists. We talked with children, young people and families who were using the service. We observed how children and young people were being cared for and talked with carers and/or family members. We reviewed care and treatment records of children and young people using the service.

What people who use the provider's services say

Children, young people and their parents or carers were positive about the service. They felt they were treated with kindness, compassion and respect by staff. They felt they were involved in making decisions about their care and treatment.

Good practice

- The “cold chain” processes to ensure optimal conditions during the transport, storage, and handling of vaccines were outstanding.
- Multi-disciplinary team working was effective.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should use a dependency tool or other methodical assessment of workloads.
- The trust should ensure all staff have appropriate access to electronically held medical records.
- The trust should make sure that the senior management team members are more visible and connected to staff in the services.

Leicestershire Partnership NHS Trust

Community health services for children, young people and families

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Community health services for children, young people and families	**Melton Mowbray Hospital**
Community health services for children, young people and families	**Loughborough Hospital**
Community health services for children, young people and families	**Hinckley and Bosworth Community Hospital**
Community health services for children, young people and families	**Ashby and District Hospital**

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Summary

- We rated this service as good because children, young people and families were protected from harm.
- The systems in place for reporting and recording safety concerns, incidents and near misses were used effectively. Staff learnt from reported incidents.
- Appropriate safeguarding arrangements were in place and staff were aware of sources of advice if required.
- There were appropriate arrangements in place for the safe management of medicines and the prevention of infection. The processes followed to ensure the correct storage of vaccines were outstandingly good.
- There was no use of a dependency tool or other methodical assessment of workloads. This meant that workloads and the pressures on staff varied across the service.

Our findings

Detailed findings

Incident reporting, learning and improvement

- The trust had an electronic system for reporting incidents. Staff were required to notify their manager on the day of the incident and told us that they knew how to use the system.
- Staff said that they had no hesitation in recording incidents as there was a 'no blame culture' and that the service learnt from incidents. This was demonstrated by evidence that incidents affecting patient confidentiality, such as lost review health assessment records, were reported.
- An incident where a young child was scalded by a hot drink at a children's centre resulted in the provision of cold drinks only in group-use rooms, but parents could still go into the kitchens to make themselves hot drinks.
- Splints to assist children and young people who had spina bifida caused pressure sores for some patients so a training session was being planned so that staff were aware of the issues.

Duty of Candour

- Staff we spoke with were aware of their duty of candour.
- We observed open and honest acknowledgement of errors and shortcomings in the service, such as when a parent reported excessive waiting time between her child's first and follow up appointments.

Safeguarding

- Appropriate safeguarding arrangements were in place and staff were aware of sources of advice if required. Safeguarding supervision provided opportunities to discuss any individual cases, which could also be discussed in the multi-agency neighbourhood forums. A safeguarding governance group met every two months.
- Staff were confident that they would spot signs of potential abuse and knew the action to take if they had any concerns.
- Children's health records were flagged to indicate any child protection alerts and if the child was on a protection plan.
- Where there were potential safeguarding issues targeted appointments ensured that a child was seen by a more senior member of staff, for example a two year developmental check was carried out by a clinical team leader rather than by a nursery nurse following two missed appointments and previous behavioural issues.
- If children or young people failed to attend an appointment, the referrer was notified and parents were contacted.
- Enhanced checks were carried out with the Disclosure and Barring Service to ensure that new recruits were not barred from working with children.
- If a young person was identified as being highly distressed and potentially suicidal, protocols were in place to provide rapid response.
- Staff helped parents ensure that homes were safe for children, for example giving information about fireguards.
- Staff were aware of, and fed information into, the child sexual exploitation hub of city and county social care

workers and the police. Any information, for example regarding looked after children who had contracted sexually transmitted infections, would be fed into this hub.

- Action to protect the safety of looked after children included immediate notification of the social worker if child or young person failed to attend an appointment or refused to cooperate in a health assessment and telephone calls from hospitals when discharging a looked after child following a serious incident such as self-harm.
- The family nursing partnership carried out detailed assessments of the risks to the pregnant teenagers, and their babies, who used their service.

Medicines management

- There were appropriate arrangements in place for the safe management of medicines.
- The "cold chain" processes to ensure optimal conditions during the transport, storage, and handling of vaccines were outstanding.
- Health visitors who had undergone additional training to be able to prescribe a limited range of medication appropriate to their specific roles told us that they attended annual workshops to refresh their knowledge.
- We saw that a health visitor carefully checked in their nurse prescribers formulary before prescribing further supplies of a cream for a rash. They could also gain online access to the British National Formulary which provides practical information for healthcare professionals involved in prescribing, dispensing, monitoring and administrating medicines.
- School nursing cover had been withdrawn from a special school and staff were observed administering medication. It was not clear that adequate training had been provided to enable them to undertake this responsibility.

Safety of equipment

- An integrated equipment store shared between health and social services enabled effective recycling of equipment. Any safety issues or problems with equipment would be addressed and the equipment made safe or removed.

Records and management

- The records that we reviewed were of good quality, up to date and reflected the needs of each individual child or young person. We saw that staff updated individual records after each consultation or intervention.
- Entries followed good practice guidelines on record keeping from professional bodies, such as the General Medical Council and the Nursing and Midwifery Council.
- The electronic records used were accessible to those involved in the care and treatment of the child or young person.
- We saw that notes were recorded electronically on a system that professionals involved in health provision for children and young people could access.
- However not all practitioners had access to the electronic system, meaning that there was incompleteness in the access to information about some patients.The trust confirmed after our inspection they were unaware of any practitioners who did not have access to electronic systems as required.
- Some practitioners were not able to add information onto this system, for example dieticians at Melton Mowbray had 'read only' access and staff had use of paper records in Market Harborough paediatric clinics.

Cleanliness, infection control and hygiene

- All the premises we visited provided clean and tidy patient areas.
- Toys provided to entertain young children in waiting areas were washable and we saw that equipment and toys in consultation rooms were wiped between each assessment.
- We saw plentiful supplies of hand washing facilities and reminders for staff and the public regarding the importance of thorough hand washing.
- A link nurse had been appointed to promote infection control.
- When visiting children at home staff followed appropriate hygiene procedures, including wearing personal protective clothing for example when weighing babies.
- Staff told us they used anti-bacterial wipes and other cleaning materials.
- To improve standards of hygiene a speech and language therapist had been given lead responsibility for ensuring infection control procedures were followed across their team.
- Infection control was a standing item on the looked after children's team meeting agendas.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Mandatory training

- Staff had completed clinical mandatory training, including infection control by 89% of staff and hand hygiene by 91% of staff. The trust target was 85%.
- Mandatory safeguarding training to level 2 for all staff and level 3 for clinicians was refreshed every three years, with specific courses, for example about domestic violence and female genital mutilation, in intervening years.
- Safeguarding children level 2 was completed by 90% of staff. This exceeded the trust target of 85% training completion.
- Safeguarding children level 3 for qualified staff was completed by 86% of staff, which was above the trust target of 85%.
- However resuscitation training for qualified staff in Adult and Paediatric Basic Life Support - Level 2 was completed by 78% of staff and did not meet the trust target.
- Additional training courses were available to community nurses which was above and beyond mandatory training. Between 1 December 2014 and 10 March 2015, community nurses attended training courses and completed eLearning (excluding any mandatory topics) for 283 training sessions. These included training courses in 'Catheterisation and Bladder Scanning' and 'Anaphylaxis for School Nurses.'

Assessing and responding to patient risk

- Staff recognised and responded appropriately to deterioration in a child's health.
- There were appropriate risk assessments in place where staff were providing care and support to children with complex healthcare needs.

Staffing levels and caseload

- We found there were vacancies in the community health services for children, young people and families services, especially in health visiting and school nursing, but these were not at high levels and had reduced.
- In September 2014 there was an establishment requirement for 270 qualified nurses (whole time equivalent) and there were 36 vacancies; a vacancy rate of 13%. In October 2014 there was an establishment requirement for just under 303 qualified nurses and there were just under 17 vacancies; a vacancy rate of 6%. In the latest available data provided by the trust in November 2014 there was an establishment requirement for 317 qualified nurses and just under 11 vacancies; a vacancy rate of 3%.
- Staff we spoke with in community paediatrics, therapies, health visitors and school nurse teams told us bank and agency staff usage was not high.
- In the Ashby neighbourhood, health visting staff told us their caseload should equate to 80 cases per working day for children between birth and five years. For example, a staff member working three days a week should have a caseload of 240.
- In Hinckley, staff told us the average caseload was 500 children or 420 families. The trust confirmed their figures for average caseloads in Hinckley were under 340 children.
- In Hinckley and Ashby neighbourhoods three health visitors and a nursery nurse told us workloads were excessive, resulting in stress and sickness absence.
- In Loughborough there were three and a half full time equivalent staff who held corporate caseloads for 1700 families, which equated to 486 cases per staff member. The trust confirmed their figures for average caseloads for health visitors in Loughborough were 350 children.
- We were told by several staff, including a school nurse in Melton Mowbray, that workloads were heavy but manageable.
- Two members of the Family Nurse Partnership team told us they had a caseload of 21, which would be increasing to 25. One staff member said, "I'm able to deliver the care I want to deliver and [I have] the time to do it in."
- We spoke with a tissue viability nurse who confirmed caseloads for their team were monitored at monthly meetings.
- Cases were categorised as 'universal', 'universal plus' and 'universal partnership plus.'
- Universal plus cases required extra targeted work, for example with breast feeding support or behavioural issues.
- Universal partnership plus (UPP) cases involved several professionals and/or there were child protection issues.
- Health visitors in Ashby told us three universal contacts could be actioned and written up in an hour; more complicated cases (UPPs) could take up to an hour or more each. Ashby is a growing area with new housing, young families and significant numbers of maternal mental health and other disabilities.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The services did not use a dependency tool or other methodical assessment of workloads. Additionally the mix of universal, universal plus and universal partnership plus cases in individual caseloads was not considered. Caseload allocations did not consider the potential impact of more complex universal partnership plus cases and weighting for these cases was not applied to caseloads. The trust confirmed health visiting and health visiting support staff were allocated to areas based on demand.
- We found workloads and the pressures on staff varied across services and in different neighbourhoods. This led to a focus on delivering the most basic services at the expense of being able to assess and provide for individual needs or limiting the amount of training that could be provided, for example to foster parents.
- School nurses stated they were, "At breaking point" with the pressure of self-harm referrals. They told us that child and adolescent mental health service had a long waiting list and accepted referrals according to the severity, with several of the referrals being passed back to the school nurses.
- There was only one occupational therapist for children's services and they told us that it was a challenge for them to meet target times for treatment. The trust confirmed after our inspection the community children, young people and families service had 15 occupational therapists.
- Staff told us that the ability to work flexible hours was positive that worked well both for them and for service delivery.
- We noted that some teams worked collaboratively to share case loads and ensure that no member of the team became overloaded. We were also given an example of where one team helped out another which was short-staffed.

Managing anticipated risks

- Contingency plans were put in place, for example for a looked after child whose carer's husband developed a terminal illness.
- Staff told us that the Trust was good at ensuring staff safety and had a comprehensive lone working protocol in place. Practitioners would aim to see people in a clinic rather than at home. Alerts were placed on the computer system if hazards had been identified at a home, such as a history of violence or aggressive dogs. Staff had personal alarms and were encouraged to take another colleague on home visits if they had any concerns.

Are services effective?

Good

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 of findings

Summary

We rated this service as good because children and families were receiving effective care, treatment and support.

- There was a clear focus on providing the best tailored service to the patients, as exemplified by neighbourhood forums which brought relevant professionals together to agree provision that best met the child's needs rather than family being referred from service to service.
- Staff had the right qualifications, skills, knowledge and experience to do their job. They were supported in gaining additional skills and expertise.
- Care and treatment of children and young people was planned and delivered in line with current evidence based guidance, standards and best practice. Consent to care and treatment was obtained in line with relevant guidance and legislation.
- There were examples of good team collaboration and effective multi-disciplinary and multi-agency working to understand and meet the range and complexity of the needs of children and young people using the service.

Our findings

Detailed findings

Evidence based care and treatment

- We saw that care and treatment for children and young people was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. For example, use of guidelines such as those from the National Institute for Health and Care Excellence. A protocol based on national guidance standardised the procedure across the three council areas for notification of placements of looked after children.
- Review of children's electric health records confirmed progress in line with care plans, for example for wounds.
- Practice issues were shared and discussed in forums provided by professional associations, for example the Royal College of Speech and Language Therapists.
- Language groups were set up in schools and work was presented at national conferences organised by the children's communication charity, ICAN.
- Staff told us that senior practitioners explained clinical reasons for approaches and that the different merits of medical equipment such as slings were discussed so that staff understood why one sling would be used in preference to another for a specific patient.
- Clinical leads identified appropriate pathways for treatment and adjustments were made as needed, for example if additional symptoms were identified by health workers these would be raised and discussed.

Nutrition and hydration

- Nutritional data was collected for children who became looked after by local authorities and action was taken where concerns were identified. Workshops for foster parents included providing healthy diets.
- Health visitors provided advice and support with breast feeding, weaning to solid food, and child nutrition.
- Community children, young people and families' services had reviewed trends in children's health and identified and targeted emerging issues. Increasing obesity in children and young people had been identified as an increasing risk to their health.
- One way in which action was targeted was through family health week, which was taking place across the organisation the week after our visit. Topics included 'Readiness for school, playing in the park and dental health.'
- Staff supported a local peer support group who had set up a breast feeding café in a local children's centre.
- Community children, young people and families' staff provided help, support and advice as part of the healthy child programme. Staff also ensured peer supporters were trained appropriately so they were able to give correct advice.

Use of technology

- We found some effective use of technology to communicate with children and their families, for example a texting service and the virtual clinic in a rural secondary school. However it was unclear that the

Are services effective?

Good

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.

switch from paper forms to parents accessing schools' websites though the Trust and uploading their child's health information prior to them starting school was working effectively.
- The looked after children team was in the process of switching from scanning in information to electronic recording of key data so that statistics, such as children's dental health or obesity levels could be easily accessed.

Outcomes of care and treatment and approach to monitoring quality and people's outcomes

- The quality of health assessments was checked with children and young people who were asked what they had gained from these assessments. Surveys indicated that children and young people were positive about their experience of health assessments and indicated that that these had provided reassurance and understanding of issues such as the importance of diet.
- Targets and desired outcomes were identified and progress monitored. For example therapy plans were given to schools for speech and language development and reviewed quarterly with targets revisited and reset as appropriate. However, not all outcome measures were specific so it was not always clear how success could be measured.
- Data collected by the Trust indicated that between January 2014 and January 2015 a home-based approach to managing constipation had helped 18 children to avoid an inpatient stay, saving over £42,000 and reducing demand on hospital services.
- In the first half of 2014/15 only two of the 77 initial health assessments for looked after children were completed within the 28 day national target. Action had been taken to address this.
- However, staff told us that the 6 monthly and annual Review Health Assessments (RHAs) for looked after children were usually completed within the required 56 days, with failure usually being due to refusal. Audit data for 2014 showed that for 5-19 years olds 72% of RHAs were completed within the target timescale in June 2014 and 81% in December 2014. For 0-5 year olds the quarterly results varied from 80% in May 2014 to 100% in December 2014.
- For 5-19 year olds audit data showed that access to mental health services was 84% June 2014 and 87% December 2014.

Competent staff

- Staff told us that they had access to good quality training, with a range of internal and external courses. These included training on alcohol abuse intervention and two-day courses provided twice a year for occupational therapists.
- Child and adolescent mental health training was provided for those caring for looked after children.
- Support was also given to enable staff to move to new posts and to pursue professional development, such as modules for a Master's degree.
- We saw that training and appraisal records were held electronically and monitored, with any overdue training flagged up.
- Staff told us that the use of temporary contracts could be unsettling for patients as well as for therapists.
- Induction and supervision provided effective support to staff. For example two recently appointed staff stated that they were given the opportunity to shadow experienced staff and then take on cases when they were sufficiently familiar and confident in their new roles.
- Staff across the services told us they were co-located with colleagues and worked closely with them to provide day to day peer support. Staff confirmed team meetings were held every other month.
- Mechanisms to supervise staff were in place and staff we spoke with across community teams told us they had supervisions. A total of 14 staff in Melton Mowbray, Loughborough, Hinckley and in the Family Nurse Partnership team told us they had clinical supervision every three months. Additionally, staff were able to request additional supervision meetings on an 'as needed' basis and these were supplemented by peer support through supervision groups.
- Newly qualified health visitors spoke positively of the preceptorship programme provided. A student health visitor had attended a Trust board meeting as part of her introduction to the service.
- Supervision was in place, for example there were regular clinical and safeguarding supervisions. We observed a newly qualified speech and language therapist receiving mentoring and that their supervision was recorded.
- We were told that staff could request one-to-one meetings if they had any issues that they wished to discuss.
- Staff had personal development plans in place and appraisals were carried out annually, with six monthly review. Staff found these meeting helpful and

Are services effective?

Good

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.

supportive. They told us that areas for improvement were usually picked up in the six-monthly caseload review and commented, "Everyone is quite open. You do not feel that you cannot bring something up if you have chosen the wrong way."

- Specialist registrars completed the initial health assessments for looked after children to ensure high quality of service.
- Nursery nurses were visited by speech and language therapists (SALT) to ensure that guidelines were being followed and to give advice on how to help children develop their language skills. We saw that nursery nurses were following the SALT guidelines and recording their actions and the progress made by children.

Multi-disciplinary working and coordination of care pathways

- Neighbourhood forums enabled effective, child and family-focussed multi-disciplinary working which focussed on the needs of specific children**.** All relevant professionals from health, social care and education were involved. Attendance levels were good and coordinated care pathways were agreed for the individual child.
- Staff told us that where there was effective communication with midwives this enabled good two-way exchange, for example regarding safeguarding concerns or if a pregnant woman or new mother was showing signs of depression.
- There was effective multi-disciplinary working in the provision of services to looked after children. For example, when a young person experienced a difficult time at school effective collaboration between a virtual teacher and the young person's nurse secured a successful placement in a different school. Although the placement was out of the county both professionals continued to provide support to the young person.
- We saw evidence of effective joint visits by specialist practitioners. Joint visiting by a dietician and a speech and language therapist had helped improve a child's feeding regime and reduced the parent's anxiety about the risk of their child choking on food. Joint visits involving a Diana children's team nurse and physiotherapist prevented a child from needing to be admitted to hospital.
- The looked after children service team had taken steps to improve the care of children from other local authorities placed within Leicestershire and Rutland. Some local authorities have bought in services from the team, but others have refused to pay for work to be carried out locally or to send their own staff when children from their areas have been identified with problems such as weight issues. The local team has now notified other authorities that they will carry out review health assessments and will charge a nominal amount to carry out any follow-up work that is identified.
- Care navigators sped up processes and reduced administration for clinicians, for example by pursuing missed appointments and making new appointments.
- Physiotherapists and occupational therapists on different bands met and discussed issues raised by cases. Team meetings every other month enabled working through case studies and learning from when things had not gone well. Information about new research or developments was shared, for example with new products such as types of slings being available for staff to try.

Referral, transfer, discharge and transition

- There was clear guidance regarding referrals, such as that for referrals to the Community Paediatric Service,
- To ensure appropriate referrals, proposed referrals were preceded by telephone calls to the other professional to discuss the referral, which was recorded on the child's heath notes.
- The Leicester City Transitions Team for Health worked with 14 -19 years living in Leicester City to help them with the transition to adult health care services. A similar transitions team was being explored for young people living in Leicestershire.
- A transition pathway was in place for young people with autism.
- A speech and language therapist had lead responsibility for ensuring ease of transition for young people to adult services. Reports were written prior to transition and joint visits were carried out when appropriate. There were, however, some problems with ensuring that the equipment needed by specific young people, and that they had accessed in school, was available for them through the adult services.
- We were told that transition arrangements and provision were under developed for young people with complex needs that were receiving occupational therapy.

Availability of information

Are services effective?

Good

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 electronic records system was effective in enabling quick access to information about patients and in enabling targeted care.
- Trust policies were available electronically. Staff told us that these policies were not always easy to locate but that work was being undertaken to improve accessibility.
- We were told that information was effectively cascaded and shared through meetings, for example team meetings and specialist meetings, such as the three monthly paediatric meetings.
- The forms completed by midwives for health visitors and the verbal handovers from health visitors to school nurses were not consistently providing all relevant information, although this could be located by trawling through the electronic records.
- Neo-natal information such as breastfeeding data was not being consistently captured for looked after children (LAC) so one of the nurses from the LAC team was going onto the neonatal unit to secure this information.
- A 'Health for Kids' website had been developed by school nurses for primary aged children, their parents and carers

Consent

- We saw that young people were encouraged to provide consent in decisions about their care, for example if they wanted their parents to be present at consultations.
- We saw that parental consent was secured for the sharing of children's information, for example at the multi-disciplinary neighbourhood forums.
- A health visitor ensured that the parent of a child with complex health needs was clear that it was their decision whether or not the toddler should attend playgroups. Permission was asked before the health visitor made further enquiries or arrangements.
- Health practitioners were instructed to establish who held parental consent and to obtain signed consent required prior to carrying out health assessments. Consent was to be sought from the social worker before making any referrals.
- School nurses would not see a child if they were unaware of the referral to their service. Parents would be notified of the right to opt out.
- Confidentiality was discussed and agreed with young people and encrypted devices were used for recording their health details.
- We were told that there was the ability for a practitioner to restrict information on the child's electronic record to specific contacts where high levels of confidentiality were required.

Good

Are services caring?

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

Summary of findings

Summary

We rated this service as good because:

- Children, young people and families were treated with compassion, kindness, dignity and respect.
- Feedback from those using the service was positive about how they were treated by staff and about how they were involved in making decisions with the support they needed.

Our findings

Detailed findings

Dignity, respect and compassionate care

- We saw that staff treated parents, carers and children with respect, kindness and compassion. This was confirmed by parents, children and young people with whom we talked.
- Staff were dedicated to providing a good service, for example fitting in an appointment for a distressed mother on top of the day's workload.
- A new mother was loaned a breast pump (fully sterilised) to help her ensure she was making an appropriate purchase.
- We observed that a health visitor working with the parent of a child with complex care needs had formed a friendly, compassionate and supportive relationship with the family.
- We saw that supportive approaches were used, for example a speech and language therapist working with a child with limited language had a good knowledge of the child's current language level. The child's achievements during the session were praised and encouraged and errors were gently corrected.
- We noted that practical advice was given in a clear, helpful way, for example when use of baby bottles should be discontinued.
- Diana children's team nurses helped prepare children and young people for going into hospital, including overcoming phobias.

Patient understanding and involvement

- Parents, carers, children and young people were involved in making decisions about their care and support, for example options to enable a toddler with complex health needs to socialise were explained to their parent. A young person told us, "I am happy with the care I receive. They explain everything to me. I am treated with respect."
- We observed that parents of younger children were involved in their children's health assessments. The health visitors checked that the parents consented to the assessment being carried out and were happy with the advice given.
- Therapists explained the benefits and risks of treatments to enable parents and young people to make informed decisions.
- We observed staff engaged well with patients and their families and involved them in agreeing targets.
- Sensitive communication helped achieve positive outcomes, for example encouraging a young person with Downs Syndrome to have a blood test.
- Where young children had terminal illnesses parents were able to specify their choice of place of death.
- We observed staff in clinics and on home visits explaining support and treatment to children and parents and allowing opportunities for any questions.
- Carers of looked after children were telephoned following the initial health assessment to check their understanding of the health needs identified and access to health services for that young person. Visual resources would be used to explain health issues to looked after children and young people, especially those with learning disabilities.

Emotional support

- Ante-natal sessions focussed on emotional engagement with the unborn baby.
- Support was available for young people who used the virtual clinic at a rural secondary school. Sensitive monitoring meant that any young person who was distressed after a skype session with the school nurse would be given immediate support.
- We saw that a health visitor responded positively and with sensitivity to a parent's 'can do' attitude rather than regarding their child as 'disabled'.
- The assigned nurses kept in contact with some looked after children after they had left care and provided them continued support, for example when one disclosed

Good

Are services caring?

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

pre-teen events that they had experienced and that were still affecting them emotionally. The nurse was able to put the young person in contact with the appropriate support agencies.

- Involvement in Y-POD, a Big Lottery funded project from March 2014 for very challenging children leaving care and the Leaving Care hub in Leicester, enabled nurses to ensure that the young people effectively connected with adult health care service, for example to obtain sexual health services.
- An allocated worker supported young people who had been in sexually abusive relationships.
- Packages of care for looked after children included actions to raise self-esteem and confidence.
- We observed a reassuring approach with time being available for parents to ask questions in a community paediatrics clinic. The doctor spent 20 minutes after the end of a clinic talking over anxieties with a parent and providing reassurance.
- The Child and Family Support Service helped patients living with life limiting, life threatening or chronic illness and their families to understand their thoughts and feelings about how the illness affected them. Therapeutic play used with children and young people included games, role-play and craft activities. Consultants would often give the parents their mobile telephone numbers. Bereavement support was offered to parents and families in the months following the child's death.

Promotion of self-care

- Young people receiving occupational therapy were given guidance on how to manage their health issues and where to seek help.
- Support for young people to manage their own treatment had achieved positive results, for example improving their self-esteem so that they started attending school or college.

Are services responsive to people's needs?

Good

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

Summary of findings

Summary

We rated this service as good because:

- Services were planned and delivered to meet the needs of children and young people.
- Interpreters and a multi-lingual cultural link support worker provided effective support to practitioners who delivered care to patients and families whose first language was not English.
- However, waiting times could be very long for community paediatric follow up appointments.
- Target times for initial health assessments for looked after children were not being met.

Our findings

Detailed findings

Planning and delivering services which meet people's needs

- Provision had been organised into eight neighbourhoods across Leicestershire and Rutland, with six neighbourhoods in the city of Leicester. This enabled flexible approaches to the differing health needs in these geographical areas.
- A family health week was being planned by health visitors for the week after our inspection. In addition to general themes such as readiness for school, the Melton neighbourhood had chosen to focus on dental health. Dental health had been identified as an issue across the Trust, and was a particular concern in the Melton area.
- In the Melton area evening ante-natal sessions were being trialled to offer more out of hours service for working women.
- Post-natal sessions were held for small groups of parents. Topics included communication with babies, healthy eating and weaning guidance.
- In Melton Mowbray a breast feeding café had been set up by local peer supporters in a local children's centre. Trust staff provided help, support and advice and ensured that peer supporters were giving the correct guidance.
- The virtual clinic being piloted at a rural secondary school was enabling young people to gain more access to advice from school nurses. Use of skype provided a way of providing more interaction with young people in a format that some found easier to participate in than face-to-face conversations with the school nurse.
- Young people leaving care had a health summary: 'My personal health story.'
- We saw that progression was carefully planned by speech and language therapist, with notes and targets written up after each visit. These were shared verbally or as written feedback to the parents so that they could encourage attainment of the targets.
- Where children or young people had complex health care needs services were delivered by the same group of practitioners to give continuity.
- Action was taken in response to feedback, for example greater flexibility was introduced regarding the locations in which review health assessments were carried out when this was raised in a 'Tell Us' survey. This meant that young people were being examined in an environment of their choice.
- Looked after children were asked what they wanted in a foster carer and participated in foster carer recruitment, for example at an open day at Leicester City Football Club. They chaired meetings in the board room at county hall and award and celebration ceremonies recognised their achievements.

Equality and diversity

- Staff received equality and diversity training.
- Policies were screened to ensure they paid due regard to equality issues.
- Interpreters were used (via telephone and in person) as required where children, young people or parents did not speak English as their first language.
- A multi-lingual cultural link support worker provided effective support to practitioners in communicating with patients and families whose first language was not English and helping with cultural and belief issues, for example about death.
- Use was made of advocates where appropriate.
- Leaflets, for example about the occupational therapy service, were available in different formats and information was provided in seven languages for people whose first language was not English informing them where they could get help in understanding the contents of the leaflet.

Are services responsive to people's needs?

Good

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

- We were told that services were made accessible as possible, for example a hoist was borrowed from the physiotherapists for a baby care session to enable a wheelchair user to get down onto the floor to practice baby massage. Home visits would be made to people who found it difficult to attend appointments.
- School nursing staff told us that children with learning difficulties or disabilities or physical disabilities were included in the National Child Measurement Programme . The trust confirmed trust teams worked in partnership to provide specialist weighing equipment and there was a care pathway in place. However, we found three clinics in which there was no provision for measuring the height or weight of children who use wheelchairs, although there were sit-on scales at Loughborough.

Meeting the needs of people in vulnerable circumstances

- Any looked after child who moved to another location within Leicestershire and Rutland remained assigned to the same nurse to ensure continuity of care.
- The Diana Service provided care and support for children and families requiring special nursing care, for example terminally ill children. The Diana nursing team completed electronic health risk management plans for all children and young people with complex physical health needs who were looked after or for whom child protection plans were in place.
- The health risk management plans informed social care about the training, equipment and medication required to care for the children and young people if they should require alternative foster placement in an emergency.
- In response to the higher rates of health issues incurred by looked after children, initiatives such as smoking cessation were being pursued.
- Two nurses were seconded to the Y-Pod project that offered intensive support for the most disengaged care leavers and young offenders. The nurses helped young people with issues such as wanting to come off cannabis, stop smoking and health conditions such as asthma and toothache to access appropriate health services.

Access to the right care at the right time

- Waiting time targets of 18 weeks from referral to initial assessment were being met across all children, young people and families services. The longest waiting time from referral to initial assessment was for the children's occupational therapy team, this wait was ten and a half weeks and was still within the target of 18 weeks.
- Other referral to initial assessment waiting times included speech and language consultations, which were eight weeks. The waiting time for community paediatrics was just over ten weeks however follow up meetings could be over ten months after the initial assessment. Waiting times for Children's Dietetics Outpatients were just over eight weeks, with follow up appointments arranged for a month, three months or six months after the initial assessment.
- We spoke with a parent with a young child at the dietetics and nutrition clinic. The parent told us that an appointment was arranged within a few days of the referral being made. Another parent confirmed the promptness with which appointments were arranged, citing a same day response to the GP referral to the clinic.
- However staff and patients told us that waiting times for community paediatric clinics and follow up appointments were too long. In one clinic which we observed a parent commented that they had waited over nine months since the initial consultation and the consultant acknowledged the excessive delay. Another parent told us that they had been waiting over fifteen months for an initial consultation appointment for their child.
- Target times for initial health assessments for looked after children were not being met.
- The virtual clinic being piloted at a rural secondary school was enabling young people to gain more access to advice from school nurses.
- A text messaging service enabled young people to text a central number staffed by a school nurse. Appointments could be arranged and the school nurse who could respond or refer the query to another colleague to give advice and support. The meant that young people always received a prompt response even if their local school nurse was unavailable.
- The Family Nursing Partnership intensive support programme for young parents could only be offered to 150 young people which was less than 13% of those eligible. (2014 data)

Are services responsive to people's needs?

Good

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

- Staff told us that it was sometimes hard to secure the occupational therapist or physiotherapist input needed for some children in their homes.
- Patients and their families were offered a choice of where to attend, for example for consultations with dieticians, with 35 clinics across the area.
- The Children's Community House at Melton Mowbray provided a good central location for families to visit, being near a large supermarket and the doctors' surgery.

Complaints handling (for this service) and learning from feedback

- Systems were in place to enable patients and families to raise complaints and staff told us that any learning from complaints would be disseminated by email or through workshops.
- Staff said that they helped parents and children access the complaints procedure if needed. If families were upset by an incident a local solution would be sought and an incident form completed if necessary.
- Any complaints were passed on to line managers who shared outcomes with staff, identifying any patterns in the complaints and any learning, such as how to respond if a similar situation arose in the future.
- Results from 'Friends and families' surveys were shared with staff.

Are services well-led?

Requires improvement

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 of findings

We rated this service as requires improvement because:

- Local leadership was well regarded by staff, as was the chief executive, however views were generally less positive about the services' other senior management.
- Staff were positive about the support they received from their local leaders and managers but were less connected with senior leadership and management teams in the children, young people and families services.
- Not all staff were aware of the services' vision and values.
- Staff perceptions of engagement and empowerment varied, with some feeling that their concerns or ideas for improvement were not taken into account.
- There were processes for obtaining the views of children, young people and families using the service.

Our findings

Detailed findings

Service vision and strategy

- The trust website stated the aims and objectives for the children, young people and families services. These included the services' aim to 'optimise the health and development of children and young people' and to 'deliver and develop care that is integrated or coordinated around the individual needs of the child and their family.'
- However we found little awareness among practitioners of the services' vision or values. One member of staff recalled that these had been handed out on a card and the vision and values were included in the self-evaluation packages given to teams in advance of our inspection.
- Some staff were aware of aims, such as attracting and sustaining a strong workforce and being amongst the top organisations for which staff would like to work.

Governance, risk management and quality measurement

- Risk management was under-developed, for example for looked after children some risks were identified but there was no indication of the level of risk or of proposed dates of completion of actions to mitigate the risks.
- There were regular audits in the service provided to looked after children. Learning from these audits included identification of some poor practice in the completion of British Association for Adoption and Fostering forms and training was subsequently arranged.
- Training provided to staff outside the organisation was evaluated and needs identified. For example the need for more tailored training to support foster carers of older children and young people.
- There was good evaluation of a post-natal support group set up by health visitors.
- Staff were given clear guidance about their responsibilities, for example through the practice guidance for health practitioners working with looked after children.
- The team leader carried out spot checks on health visitors' record keeping to ensure adherence to the trust's requirement for records to be updated within 24 hours.

Leadership of this service

- Staff felt that the trust's chief executive was visible. He had visited services, for example attending a neighbourhood forum and a school nurse 'time out' day. Staff told us he seemed approachable, genuinely interested in what everyone was doing and, "Very open to discussion." A non-executive director had accompanied a Diana children's service nurse on a home visit.
- However, apart from those based at the Families, Young People and Children's Services' main office, staff were less positive about the visibility and accessibility of other senior managers.
- The service benefitted from stability in senior management, for example with the Director having been in post prior to the creation of the trust.

Are services well-led?

Requires improvement

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 were positive about the support they received from their local leaders and managers but were less connected with senior leadership and management teams in the children, young people and families services.
- The looked after children's team was well managed and was represented at local safeguarding meetings and at trust board level.
- Staff generally regarded their local line managers as supportive and effective, for example in securing the Children's Community House at Melton Mowbray as a base.
- Staff told us that the previously high levels of stress and sickness absence had reduced and communication, morale and performance had improved. One member of staff described their line manager as supportive and ready to provide reasons for decisions. They told us, "The management I have been privileged to have in the last 18 months has surpassed my expectations." Another member of staff described their line manager as having an open door policy and being good at listening and at managing conflict.
- There were weekly newsletters and emails from the senior management team.
- Training in leadership at a local level was available to team leaders and was described by them as, "Excellent".

Culture within this service

- Some staff felt that there had been an improved culture in the last two years and that there was more readiness to listen to staff, with action completed such as the provision of a base for Diana children's service nurses at weekends.
- However, some of the changes within the trust were impacting on morale, especially where staff were having to reapply for the posts that they currently held.
- A small number of staff, fewer than eight of the 82 staff we spoke with, told us they did not feel supported by their managers and felt senior management was very 'top down.'
- One staff member told us, "The decisions that are made are forgone conclusions – even if we put across strong argument." Staff therefore felt disengaged and were not convinced that the changes being made were to the benefit of patients or of the staff caring for them.
- In particular health visiting staff had made suggestions and raised concerns, for example about workloads, but felt that senior managers were not willing to listen, "You get told that you are moaning, that you are being unconstructive in putting that forward. When we make criticisms of the system that is not what is wanted."
- Most of the staff we spoke with described good support and effective working relationships within their teams and with their immediate line managers. One staff member told us, "It is 20 miles away from where I live but it is worth the journey. It is a very supportive organisation."
- We were told that local managers regularly attended team days and also invited staff to attend management meetings.
- Staff were proud of their work and the outcomes achieved for the children and families they supported.

Public and staff engagement

- The NHS Friends and Family Test was used for community health services for children, young people and families. Staff told us that they were encouraged to give out Friends and Family cards to every service user, for example health visitors gave out the 'Friends and families' surveys to parents and carers of 0-4 year olds.
- An initiative was under way to identify creative ways of obtaining the views of looked after young people. Social workers, leaving care workers and foster carers had been invited to a meeting to look at other means of obtaining feedback, such as texting.
- Young people were engaged in their healthcare, for example through the FAB weight loss group for young people in care.
- Family nurse partnership interview panels included teenage mothers.
- Staff in some parts of the service felt empowered to come up with new ways of tackling issues, for example trialling an evening ante-natal session in the Melton area to improve access for working women.
- The Trust had taken action to engage with staff, including 'Listening in Action' forums to enable staff to participate in discussions. Staff described these as providing time for problem solving and was securing ideas from staff to improve efficiency, for example in delivering administrative tasks.

Innovation, improvement and sustainability

- A virtual clinic was being piloted at a rural secondary school. Using skype, this was enabling young people to gain more access to advice from school nurses.

Are services well-led?

Requires improvement

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.

- A mental health nurse with school nursing experience had been appointed to a one year developmental post of children's community liaison nurse helping school nurses to support young people with emotional issues. By providing timely support, the aim was to help young people avoid developing mental health problems and the need to be referred to Children and Adolescent Mental Health Services.
- A video addressing barriers or problems that children encountered when entering school was being produced. It was aimed at parents and children and featured two five year olds who identified possible issues for young school starters.
- Pilot projects were monitored and audited to assess their cost-effectiveness.