Care Quality Commission

Humber NHS Foundation Trust

RV9

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 20-23 May 2014 and 5 June 2014
Date of publication: 03/10/2014

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

Summary of findings

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Summary of findings

Overall summary

The services we inspected were provided for children, young people and families, and included health visiting, school nursing (including special school nursing), speech and language, occupational and physiotherapy among others.

We found that there were processes to ensure children and young people were safeguarded and staff had an excellent knowledge of child protection. However, we found a large number of documents had not been scanned onto the electronic record quickly enough. This meant that members of the multidisciplinary team could not access all the available information. We asked the trust to take urgent action at the time of our inspection and made another unannounced inspection. We found that, while most of the scanning had been undertaken, there was a significant amount outstanding in one area. However, summary information was available on the electronic system and we were assured that other professionals, for example GPs, were not reliant on receiving the information via the electronic record. This reduced the risk to children, young people and their families.

We were concerned that some services, such as school nursing and health visiting, had high caseloads. However, caseload figures provided by the managers were not consistent with those provided by clinical staff. School nurse ratio to secondary schools was in excess of Royal College of Nursing guidance, which affected their responsiveness to children's and schools' needs. Staff told us they worked in silos and 'on the hoof' due to their work pressure.

Services were effective and we found good examples of multidisciplinary working to ensure national care programmes, such as the Healthy Child programme, were implemented. The service also performed well for child immunisations. We saw many examples of compassionate care provided by staff, which gave children and families the opportunity to be involved with planning their care while maintaining their privacy and dignity.

Care was not always responsive to people's needs because of the lack of some services, and because they had lengthy waits to see some specialists, such as speech and language therapists.

The service was not well-led as not all staff were sure of the vision or strategy of the service they worked in. We spoke with staff across services who were upset at their workload and lack of support from some managers within the service. We had significant concerns about the service.

Summary of findings

Background to the service

The services provided for children, young people and families included health visiting, school nursing (including special school nursing), speech and language, occupational and physiotherapy, among others. Services were provided in clinic settings, as drop-in sessions and a large number of children and families were seen in their own home. Therapy services were provided by Humber NHS Foundation Trust in both Hull and East Riding; community health services were provided in the East Riding of Yorkshire only.

Our inspection team

Chair: Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust

Team Leaders: Cathy Winn, Inspection manager and Surrinder Kaur, Inspection Manager, Care Quality Commission.

The Community health services for children, young people and families inspection team included CQC inspectors, a children's nurse, a children's service manager, a paediatric therapies manager and an Expert by Experience who had used services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 mental health and 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 hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 20 to 23 May 2014 and an unannounced inspection on 5 June 2014. During the visits, we held focus groups with health visitors, school nurses and specialist nurses. We visited community teams based in each locality in East Yorkshire and therapists based in Hull. This included services provided at East Riding Community Hospital in Beverley, Hessle Health Centre, Bridlington Medical Centre, Brough Primary Care Centre, Rosedale Community Unit in Hedon and Victoria House in Hull.

We also spoke with a range of staff at different grades including health visitors, school nurses, service managers, support staff and the senior management team. We spoke with staff and children and families during our inspection at clinics and drop-in sessions as well as at teaching events. We undertook a number of community visits with health and care professionals and spoke with people receiving care in their own homes. We observed how people were being cared for and reviewed care or treatment records of people who use services.

Summary of findings

What people who use the provider say

Between September and December 2013 the Hull integrated paediatric therapies service undertook a patient experience survey. It assessed parent and carer feedback, and child and young person feedback. It was completed by 116 parents and carers, and 79 children and young people. It found that 77% of parents and carers were extremely likely to recommend the service they received, while 87% of children and young people reported a positive experience.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that all records, electronic or paper based, are accurate, up to date and fit for purpose.
- The trust must address the leadership and staff engagement issues within the children's services.

Summary of findings

Action the provider or SHOULD take to improve

- The trust should review school nurses and health visitors' caseloads and ensure they are manageable in accordance with national guidance.
- The trust should work with commissioners to ensure service specifications/agreements are in place for all services.
- The trust should continue to address the speech and language therapy waiting lists in Hull.
- The trust should work with partners to address the delays in getting specialist equipment to children and young people in a timely way.

Humber NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

The five questions we ask about core services and what we found

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We found that staff knew how to report incidents and there were mechanisms in place to feedback outcomes of serious incidents and changes to practice. However, not all staff had received feedback about minor incidents they had reported. Staff also knew about infection control principles and we observed staff regularly washing their hands before and in between contacts with children and parents. There were good safeguarding arrangements in place and staff regularly received safeguarding supervision in line with best practice.

During our inspection we were made aware of a large number of documents at two sites that were waiting to be scanned into the electronic notes. Some of these had been waiting for three months or more. We were very concerned that other professionals would not have access to potentially sensitive and important information. We brought our concerns to senior managers during our inspection and asked them to take action to address the situation and revisited areas as part of our unannounced inspection. We found while most of the scanning had been done, there was a significant amount outstanding in one area. However, summary information was available on the electronic system which reduced the risk to children, young people and their families.

Detailed findings

Incidents, reporting and learning

Incidents were reported using an electronic incident reporting system. This was being rolled out across the trust and was at different stages of implementation during our inspection. Staff we spoke with were confident in reporting incidents and aware of the procedures to follow to do this.

Are services safe?

Staff received feedback in relation to significant or serious incidents via the trust's Blue Light Bulletin. This was sent to all staff and outlined the incident, learning and changes to practice that had occurred. We saw meeting minutes that showed incidents were discussed with some teams. One member of staff we spoke with told us of an incident, how it was investigated and the changes they had made to the environment to mitigate future risks. However, some staff said they always received feedback following reported incidents, particularly if they were considered relatively minor.

Cleanliness, infection control and hygiene

Areas that were used for seeing children and families were clean and well maintained. There were adequate hand washing facilities for staff and patients in the clinic settings and we saw staff regularly wash their hands between patient contacts. Staff visiting patients in the community had personal hand sanitizers available. We saw that before equipment was used, such as scales, staff ensured they were cleaned to an acceptable level. There were signs in clinics and offices advising patients, families and staff to wash their hands. There were also gel dispensers available throughout the clinics and the community hospital we visited.

Maintenance of environment and equipment

Community staff such as Health Visitors regularly used equipment such as portable scales. Scales and some other equipment were also used in clinic settings. We saw that the scales were regularly serviced and calibrated.

Medicines

The team leader for the health visitors told us that all the health visitors were nurse prescribers, with prescribing being based on the Nurses' Formulary (V100). They told us it was trust policy that only health visitors who were qualified nurse prescribers were employed by the trust. These competencies were reviewed each year as part of a national competency framework.

Safeguarding

All staff had received safeguarding training as part of their induction and ongoing mandatory training. Depending on their role, adult and children's safeguarding training was provided to different levels, for example school nurses had been trained to level 3 in safeguarding. The lead therapist told us that 90% of therapists had received safeguarding training. The level for safeguarding training across the trust as a whole was also at 90%. We saw that there was a robust safeguarding supervision process in place for staff to discuss safeguarding concerns and also to be challenged about their safeguarding decision making. This ensured staff's practice was peer reviewed and cases were considered by more than one practitioner. Staff told us that they regularly received safeguarding supervision and all were positive as to its value and we saw a rolling programme of supervision was in place.

Staff we spoke with were confident of the role in safeguarding and accurately described the escalation processes if they believed someone was at risk. They also reported that they had a positive and collaborative relationship with the local authority safeguarding staff and social workers. They told us that the leads for safeguarding within the trust were easily contactable and approachable.

We spoke with staff who told us how they ensured they monitored children who were the subject of safeguarding concerns, including face to face and telephone contacts. If the children did not attend an appointment, then these children would be seen at home.

Records

The service used an electronic records system for recording patient contacts, letters received and sent and evaluating care plans. We saw that staff on community visits wrote details on paper records and then updated the electronic system later in the day. Health visitors told us there was no system in place for keeping paper records when at patients' homes. They told us they wrote them in their diaries and others put them onto pieces of paper. We found some staff used notepads for initial records and had had this approved by data management even though it fell outside of the trust's policy on record keeping. This lack of consistency posed a risk in ensuring patient records were accurate. The system also meant there was a risk of transcription errors when staff updated the electronic record. We discussed these issues with the general manager responsible for health visitors and school nurses, as well as one of the health visitor team leaders. They said that the issues related to the records described above had not been placed onto the trust risk register, or onto any local directorate risk registers. We saw that the general standard of record-keeping had been identified as a risk on the trust's corporate risk register.

We found at two locations, Hessle clinic and Rosedale centre, a large amount of records (circa 250 at one location), many of which were several months old and had

not been scanned onto the system. We also noted that many of the letters had not been clerked in (e.g. date stamped) and as such staff were unsure of when the letters arrived. These documents included safeguarding records and referrals from the local minor injuries unit. There were also 30 antenatal referral documents from midwives which had not been put onto the system at one location. Clinical staff informed us they had raised their concerns with managers. We reviewed business meetings held monthly between January and May 2014 and found issues arising from the scanning of documents were raised at the May 2014 meeting. It was stated that although this was not on the risk register the general manager had raised it with the associate director.

We asked the trust to take urgent action regarding this matter at the time of our inspection and revisited areas as part of our unannounced inspection. We found that the trust had responded and most of the scanning had been undertaken, although we found there was a significant amount outstanding in one location. The process for scanning this information commenced on the day of our unannounced inspection and we found summary information was available on the electronic system which minimised the risk to children, young people and their families. However, we remained concerned about the sustainability of the system to manage documents and ensure that records were updated in a timely way.

Lone and remote working

There was a lone working policy at the trust and staff were aware of their responsibilities to themselves and others when lone working. Health visitors and school nurses told us they were provided with trust mobile phones when they were working out in the community. They said that following risk assessments they would sometimes undertake home visits with a colleague.

Staffing levels and caseload

Some staff raised concerns regarding staffing levels and caseloads. Information regarding actual caseloads for Health Visitors varied between that supplied by managers and those reported by staff and the electronic records system. However, staff had varying caseloads, with those covering more deprived areas getting fewer clients to manage. This was based on a recognised caseload management tool, the Cowley weighting tool.

Health visiting staff we spoke with individually and in focus groups told us that they had high caseloads with a large number of vulnerable children. The Community Practitioners and Health Visitors Association (CPHVA) say that caseloads for health visitors should be an absolute maximum of 400 with an average caseload being 250. The CPHVA say that unless caseloads are manageable it can have a detrimental effect on the relationship a health visitor has with a family or to properly assess needs in line with the Healthy Child Programme.

We received figures from the trust that showed average caseloads were under 300. However, we received information at two sites from the electronic records that showed staff had an individually allocated caseload and there was also a further team caseload for unallocated children between the ages of 1 and 4. These were children who were being followed up routinely as part of the Healthy Child Programme. The health visitors remained a key point of contact for these children. We found that when the unallocated team caseload was taken into account with the allocated caseloads, the numbers for some health visitors was in excess of 400. We were aware that the trust was in the process of recruiting new health visitors as part of the national programme to reduce caseload sizes. We saw that a Health Visiting plan was in place; this had been completed in 2011.

Part of the role of the health visiting team was to scan received documents, such as safeguarding information, onto the electronic record system to ensure the information was accessible to the relevant professional. The teams in some areas did not have capacity to do this and this resulted in the large number of unscanned documents we found. Staff reported there was insufficient administrative support.

In school nursing, we saw one specialist practitioner (school nurses are required to undertake further study and qualifications) was covering as many as 4 secondary schools and associated primary schools. Management of this service told us there was a high number of Looked After Children (LAC) within the service. Whilst they were supported by a number of staff nurses, Royal College of Nursing (RCN) guidance specifies there should be one school nurse to one secondary school. This was compounded by the school nursing service operating to a lapsed service agreement. The age that school nurses are responsible for children has now risen to 18. This meant that the service was responsible for more children and young adults than was being reflected in their service

Are services safe?

agreement or staffing plan (though we were aware a caseload management tool was in use). There had been a restructuring of school nursing implemented in September 2013 which saw some nurses now working term time only and reduction in school nursing hours.

Deprivation of Liberty safeguards

Staff told us that no patients were subject to restrictions. We saw that staff had received training in the Mental Capacity Act 2005 and demonstrated a good knowledge of the Act.

Major incident awareness and training

We spoke with the general manager responsible for the service, and a team leader for the health visitors, who told us they knew where they could access information about major incident and business continuity plans on the trust's internet. The lead therapist told us they were aware of the trust's major incident plan and we saw there were effective systems in place to initiate local emergency plans, such as the heat wave plan.

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 of findings

We found the services provided to be generally effective for children, young people and families. The multidisciplinary team was working effectively to implement national programmes, such as the Healthy Child Programme, and worked in partnership across organisations. However, there was a lack of a formal referral processfor staff to refer children and young people to mental health services.

We saw there were positive patient outcomes in services, including therapy services and child screening. Staff carried out their roles competently and most had completed their mandatory training. We saw that some professionals working across services had specialist qualifications in the field they worked.

Detailed findings

Evidence based care and treatment

We saw that children's and families' services were providing care and treatment in line with some National Institute of Health and Care Excellence (NICE) guidance but not all, such as enuresis care which was not commissioned. The Healthy Child Programme was being effectively managed between the Health Visitors and School Nurses amongst others. This was reflected in an emphasis on parenting support, integrating services, promotion of breast feeding and prompt identification and referral of children who needed specialist support and treatment.

Immunisations were given to children in line with national guidance and policy. In school nursing, a significant number of children had received the HPV vaccine making the trust one of the best performers in this benchmark nationally. There had been national recognition of work done in therapies around postural management.

Some services were involved with research. The speech and language therapy service was working with The Communication Trust to have a therapist in 16 schools one day a week, engaging children and teaching assistants to develop speech and language strategies and techniques in schools.

Nutrition and hydration

Children who were found to be in need of specialist assessment were routinely referred to the dieticians.

Patient outcomes

The service measured outcomes in a number of ways. The occupational therapy services were moving towards the use of the Therapy Outcome Measures. This is an internationally recognised tool for measuring interventions and outcomes in people receiving care. This allowed for ongoing assessment and re-evaluation of priorities for children using the service.

The National Child Measurement Screening Programme, which is a screening programme for children in year 6, was being effectively implemented and 98% of children were being appropriately screened and assessed in line with the national programme.

School nursing was aware of the need to capture 'soft' data in some of their interventions. They had undertaken a number of case studies in school nursing to highlight soft data outcomes. This also fed into the commissioning plan and priorities for children and young people in 2014/15.

Performance information

We saw that targets were being met for the Healthy Child Programme in line with commissioning arrangements through health visiting and school nursing services. There were service improvement plans in place for services and we saw the service improvement plan for speech and language therapy that highlighted challenges for the year and opportunities for improvement.

Some services such as occupational therapy were meeting targets for children to be seen in within 18 weeks of referral.

We found some services received regular feedback from children, young people and families using the service. In one area, we saw 81% of people would be extremely likely to recommend the speech and language service to a friend and 19% were likely to. The service had also developed a visual tool for children to be able to feedback their experiences of the service.

Are services effective?

Competent staff

Staff had received an induction when they joined the trust and received mandatory training in areas such as safeguarding, infection control and basic life support. Some staff such had specialist training such as Health Visitors and School Nurses and some therapists. We also spoke with a principal occupational therapist at Beverley Community Hospital who told us there was a robust program of monthly supervision in place, as well as yearly appraisals. They also told us that staff were supported in obtaining degrees in professional health studies, and that eight staff had recently completed their degree or were working towards it. Staff told us that they were supported to ensure they maintained their professional registrations. We saw a number of skills competencies in place for clinical staff including the Leicester Clinical Procedure Assessment Tool.

We saw that appraisal rates were high in some services and staff confirmed that they had had appraisals in the last year. There were ongoing formal and informal supervisions for staff in addition to specific safeguarding supervisions. Though appraisals had scored poorly on the last staff survey, staff told us that their appraisals had been fair and allowed them to reflect on practice and plan for the future.

Multidisciplinary working and working with others

We saw effective multidisciplinary working in partnership with other organisations such as the local authority children's services, local schools and the independent sector. There were regular inter agency safeguarding meetings to ensure the safety of children and families using the services.

Staff engaged with local acute hospitals to ensure children discharged from hospital were followed up and further supported where required.

We saw that children who were under the care of speech and language therapists were sometimes seen in school as well as in the clinic. We were told that this gave staff the opportunity to see children in their daily lives and they could also give help and advice to teachers so that children benefitted from a continuity of care and treatment.

There was effective multidisciplinary working in special schools. We observed a joint assessment of a child by a number of different therapists who developed a treatment plan, showing which professional would lead on which aspect of care and a date set for multi-agency evaluation.

We visited the paediatric occupational therapy service at Beverley Community Hospital and reviewed patients' health records which provided evidence of 'early support family meetings'. These are meetings attended by professionals who are involved with the health and social care of a child or young person, and who discuss this person's needs and their holistic overarching care needs. The records showed that these meetings were attended by a disability social worker, representatives of health or social care charities, a GP, a representative from the school, and community paediatricians.

We asked about referral pathways for children requiring the services of children's and adolescent mental health team (CAMHS). We were told that there was no formal referral criteria for school nurses to use when referring children and young people to the service. Another person told us that in the first instance they would discuss children's needs with the clinical psychologist. There was inconsistency which meant people were at risk of not being referred to the appropriate pathway in a timely way.

Are services caring?

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

Summary

Children and families were cared for compassionately by dedicated professionals. We saw many examples of care that treated children and their parents and carers with dignity and respect. People were involved with their care from consent to determining care plans. We saw that parents and carers were encouraged to engage in care and treatment plans and work in partnership with professionals.

People we spoke with were uniformly positive of the care they received from services. We saw that they were offered practical and emotional support when they required it and people were encouraged to care for themselves, where appropriate but always with support.

Detailed findings

Compassionate care

We observed compassionate care and treatment given to children and their families based on individual needs. Parents and carers gave positive feedback about the service they received, one of them told us: "They just care about us; it is as simple as that, they just care." Another person told us, "She has built up a fantastic relationship which helps enormously with his confidence."

Dignity and respect

We saw children and families being treated with dignity and respect. In one clinic we saw staff take a child and their parent to a quieter place as the parent wanted to discuss something personal. The member of staff ensured the person had the time and space for a confidential discussion.

Patient understanding and involvement

Children and families were given information and encouraged to be involved in decision making about the care and treatment for their children. We saw numerous examples of people being given information and asked of their understanding around treatment and potential referrals. Parents and carers we spoke with told us that they knew who their named health visitor and therapist was and that they were able to contact them if they required support and advice. One person told us; "Excellent service provided. Very happy with health visitor support."

Health Visiting staff said that through initiatives such as the Healthy Child Programme, they were able to proactively engage with children and families through the preschool years until their care was taken over by school nurses at the age of 5. This gave them an opportunity to develop meaningful relationships over this period. One health visitor we spoke with talked passionately about involving fathers more in the relationship between healthcare professionals and mothers and babies as this had been shown to improve support and increase breast feeding rates nationally.

We observed a number of therapists as they provided care and treatment. They did so in a way that was age appropriate to the children they were treating, respecting them as individuals. We saw them address the child, ask questions about what they considered to be the problem and how they might improve it. This active engagement ensured a positive relationship between therapist and child.

We also observed that the national electronic system project was explained to parents and carers in detail including the implications for them as individuals and asking their consent before proceeding.

Emotional support

Emotional support was provided to children and families. We observed staff providing informal emotional support on numerous occasions, validating people's feeling and emotions, giving them time to talk and reflecting back. Antenatal visits in the clinic and in people's homes fostered a trusting relationship that allowed the staff to offer emotional support to people. We saw staff ask specifically about people's mood and feelings during assessment and staff were able to tell us of how they would manage and if necessary, refer on people who required more intensive emotional support, in line with national guidance on post-natal depression.

We spoke with staff who ran a baby group. They told us one of the benefits of the class was to get new mothers and fathers to meet other people with similar experiences and similar situations as this was a good way of ensuring people did not feel isolated and gave another avenue of emotional support.

Are services caring?

Promotion of self-care

Self-care was regularly promoted to people through clinics and home visits. People were encouraged to learn new skills such as basic life support for babies and children at baby groups. We saw parents given strategies for managing behaviours and conditions and they were reassured that they could receive support if required.

Are services responsive to people's needs?

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

Summary of findings

Staff had made efforts to plan services for hard-to-reach groups and had engaged with different patient groups in the community. Children and families using some clinics were able to choose when to attend and had flexibility in which professional they saw and at which location. Children in secondary schools benefitted from a weekly school nurse drop-in clinic.

However, we found that services were not always responsive to people's needs. School nursing services did not have an up-to-date service agreement between themselves and commissioners of services. There were significant delays in beginning treatment in some services, such as speech and language therapy, though the length of delays varied between East Riding and Hull. There were delays in getting specialist equipment to children and young people in a timely way.

We saw that staff and teams learned from complaints and practice was changed in response to them.

Detailed findings

Service planning and delivery to meet the needs of different people

We saw that in some areas of the service, innovative work had been carried out to increase the engagement in health services of 'hard to reach' groups. For example, we saw a programme of engagement for the local traveller community which had been run with positive results in terms of engagement.

Access to care as close to home as possible

People were able to be seen at regular clinics close to where they lived. There were a number of different sessions that were run on a 'drop-in' basis allowing flexibility for families. For mothers immediately antenatal, the health visitors saw them at home.

In school nursing we saw that 'drop-in' sessions were run at secondary schools weekly, giving children and young people the opportunity to engage confidentially with a healthcare professional.

Flexible community services

Parents and children were given the opportunity to use some services that would be considered out of area. We spoke with two families who told us they had moved a few miles out of the area but wanted to maintain continuity of care. They were able to use services from their original clinic to ease the transition into another area.

We saw that clinics for some services were operated on a drop-in basis over a number of days a week, giving families' flexibility in when they could be seen and which services to use.

Meeting the needs of individuals

We met dedicated staff across the services that were endeavouring to tailor the services to the needs of individuals. The services were designed around national guidance and programmes such as the Healthy Child Programme. The special school nurses would visit children at home as well as at school. They told us that this holistic assessment ensured they could develop a care plan that would meet all the child's needs. In speech and language therapy, we saw children being encouraged to use other forms of communication such as Makaton if their verbal language skills were not developed.

We spoke with the team leader for school nursing who told us they were not funded to provide a service for enuresis, in accordance with NICE guidance, though they told us that they did provide advice for enuresis. Staff told us of their concerns in not providing this service as enuresis assessments could show up other health concerns.

Speech and language therapy had long waiting lists in Hull. Children were triaged approximately 12 weeks after referral and then referred to the appropriate treating team. For some children (in the 0 – 3 age group) this meant a further wait of 39 weeks to see a speech and language therapist and begin treatment. We saw that the service had identified concerns in waiting lists and that the situation was being monitored and addressed with some waiting times reducing. However, in May 2014, the longest wait at two clinics was over 40 weeks and 84 children were waiting over 18 weeks to be treated. We were told by staff that in their professional opinion, some children did not need to be seen in triage as they clearly needed specialist care, but that most children were still seen first in triage. Staff told us that the biggest pressure on their service was waiting times and caseload sizes, exacerbated by sickness and maternity

Are services responsive to people's needs?

leave. Staff made it clear however, that they would contact some people by phone if they required urgent advice and that the service operated an open referral system in line with Royal College of Speech and Language Therapists guidelines.

Staff across sites told us that there could be delays in getting specialist equipment to children and young people in a timely way. Members of the occupational therapy staff for East Riding and Hull told us there were delays in accessing equipment, especially when a patient had additional needs. We were told the waiting time for equipment was generally between three and six months. We discussed these issues with the responsible general manager who told us they were aware that there were delays. They told us these delays were caused because a joint panel of health and local authority commissioners had to decide on equipment requests. This caused delay which was exacerbated when the patient had a long term condition as this then meant that the requests had to go to another panel that administered those receiving continuing healthcare. The general manager told us that staff had been asked to put any delays onto the risk register. This was not identified on the corporate risk register.

Moving between services

We found that for some services there were no formal transition arrangements in place. We were told that in some therapy services that when children transitioned to adult services they were given a discharge report outlining their future therapy needs.

We were told the raising of the school leaving age caused problems in transition as the joint local authority and health commissioners did not have a plan for post 16, so the school nursing service are working with children and young people up to 18 years of age without the necessary staff leading to a prioritisation matrix. The 'prioritisation matrix' consisted of three priorities with the highest being priority 1 and the lowest priority 3. Priority 1 includes safeguarding, immunisation and sexual health provision; priority 2 includes bereavement support; and year six transitional support; whilst priority 3 includes contributing to the healthy schools programme, parenting programmes, and supporting schools and children with long term conditions.

Children with long term conditions were transitioned to 'specialist services' sometimes provided by other organisations such as epilepsy specialist nursing from City Health Care Partnership CIC and other services at the local acute trusts.

Complaints handling (for this service) and learning from feedback

We spoke with staff that were able to tell us how they managed complaints at a local level including the importance of local resolution. All staff told us they knew how to escalate a complaint to their manager.

A lead therapist told us that they would discuss any complaints with the therapist who might be the subject of the complaint. Any learning from the complaint would be then discussed at team meetings. We reviewed the minutes of a patient experience meeting attended by the general manager and the lead therapists in May 2014, which contained a section where complaints were discussed.

We saw team meeting minutes that showed how a recent complaint had been discussed and what learning had been taken from the event.

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 of findings

We found that staff were not all aware of the vision and strategy of the service they worked in, or for the trust as a whole. Some service agreements were either not in place or plans were not sufficiently clear. This meant determining or defining a strategy was not always possible. The service had risk registers, but some risks, such as the scanning of documents, were missing as the risk had only been identified a few days earlier. This meant the service did not operate an effective system to identify and monitor risks.

The culture within the service was mixed. While some staff were very positive of their role and teams, others were visibly upset when talking to us about the pressures they faced and the lack of support they received. A restructure in September 2013 had created a degree of uncertainty and some staff were left feeling disengaged and unsupported with the service management. We saw locally, some managers had been aware of the pressure on staff and had taken initial steps to address it.

We had significant concerns as to the sustainability of the service, due to our concerns around record keeping, caseload management in some services, the lack of key service agreements, such as for school nursing, the morale of staff working for the service and the apparent disconnect between staff and service management.

Detailed findings

Vision and strategy for this service

Staff gave mixed responses when asked about the vision and strategy of the service. Some staff told us that they were unaware of a vision or the direction of travel of the service. Other staff were unable to articulate the vision for the trust or the service in which they worked. Some service level agreements were not in place for key services and some contracts were 'loose', for example the speech and language therapy service agreements were for children between 0 - 19 years of age with no numbers illustrated. This made it difficult to develop a strategy for the service.

We reviewed the service plan for therapies, for the period 2014 – 19 which was in 'draft' format. It provided a profile of the service and the strategic context within which it operated. The paediatric therapy service comprised physiotherapy, occupational therapy, and speech and language therapy. It contained a vision which saw the service supporting children to reach their full potential through the provision of an integrated service, working in partnership with other providers. The strategic context described how local authorities were the lead agency for children's services. However, although there was a 'SWOT' ('strengths, weaknesses, opportunities, threats') analysis for speech and language therapies there was not one for the other therapies, or for the service as a whole. There was no analysis of the delays said to be caused by joint commissioning arrangements. There should be a clear service plan for a service to develop strategically and serve the local population. The document did not set out a clear plan.

Guidance, risk management and quality measurement

There were risk registers available at service level for therapies and the service as a whole though some areas of concern that had been identified by the service such as records and scanning documents were not on the risk registers. We were aware that some records had been previously stolen from a member of staff's car though this issue was not on the risk register. We spoke with a senior therapy manager who had a good knowledge of the local service risk register and we saw it was regularly reviewed and updated. Some performance and quality measurement was completed using the electronic records system.

We found that there was a patient experience group which was led by the general manager, lead therapists and service managers, who met on a bi-monthly basis to discuss issues related to the patient experience. We reviewed a meeting of the group which occurred in May 2014 and which discussed the therapies action plan. We also reviewed a paediatric integrated therapy services patient and public action plan for 2014 – 15, which identified action around the survey described above. It also stated as an action that the work around the survey had been shared with the overarching trust patient and public involvement group.

Are services well-led?

Leadership of this service

Staff were able to tell us who their managers were and had a clear idea of the management structure in the service. Most staff spoke positively of their direct line manager, but some staff told us that senior management within the service were not visible.

We spoke with service managers who had a clear understanding of their service, its challenges and gaps. One manager told us that they struggled to develop a vision for the service as they were just 'trying to make the numbers add up for the service'. One service manager told us that their general manager had changed twice in the last 18 months due to restructuring which had generated a level of uncertainty.

Staff told us that in some services that there were poor channels of communication between managers and staff. They said that they were not always kept informed of changes to the service or changes to the way they worked.

Culture within this service

The culture within the service was mixed. Some staff told us with obvious passion and pride in what their service was doing well. A lead therapist we spoke with told us there was an open culture where risks were shared and joint action taken. This was corroborated by the minutes of patient experience meetings where we found incidents were discussed as regular tabled agenda items.

A number of staff we spoke with privately and in focus groups were visibly very upset when describing the pressure they were under in terms of caseloads and in managing their clinical work. They told us they felt unsupported by some local and senior management within the service and that their concerns were not always taken seriously or acted upon. These staff represented several of the services within children's and families' services though it should be noted that some of the staff we spoke with staff told us they felt adequately supported by their manager and team. A number of staff we spoke with told us they regularly felt under pressure to work over their hours to get their work completed, whilst others said they completed work at home. The last staff survey put the trust in the bottom 20% nationally for work pressure felt by staff.

A comparatively recent restructure in some of the children's services had left staff feeling disengaged and unsupported by senior management and in some cases alienated. One member of staff told us that they were working in silos and felt that senior management considered their jobs worthless. Other members of staff told us that they lived in fear of management and were concerned about repercussions when speaking out. The last staff survey put the trust in the bottom 20% nationally for staff support from immediate managers.

Some managers had recognised their service was under pressure and had asked staff to complete the Health and Safety Executive stress questionnaire. We saw an action plan had been developed from the results and risk assessments completed.

Public and staff engagement

We found that between September and December 2013 the Hull integrated paediatric therapies service undertook a patient experience survey. It assessed parent and carer feedback, and child and young person feedback. It was completed by 116 parents and carers, and 79 children and young people. It found that 77% of parents and carers were extremely likely to recommend the service they received, whilst 87% of children and young people reported a positive experience. It also asked what worked well, what could be done better, and what ideas people had for service improvement. Although people described the care given in positive terms they identified more frequent appointments as being a priority. They also identified telephone contact whist waiting for an appointment as a means of improving the service. The survey analysis also contained the actions being undertaken by the service in response to the suggestions made. These included the introduction of a telephone review to assist with waiting list management, and proposing that transition planning be reviewed during 2014 -15 as part of ongoing service improvement.

We also discussed this satisfaction survey with the principal occupational therapist who told us that these generally positive results had been shared with the team.

A similar review was conducted for people using the hearing impaired service in Hull. This more specialist survey took the views of 13 parents and carers, and 16 children and young people. The results were positive apart from two children or young people who reported a "between positive and neutral" experience. The opportunities for service development identified by the

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trust, following comments made by people who completed the survey, included offering support during the school holidays. They also included improving the information as to the therapist's role given to families.

The team leader for the health visitors told us that they have an electronic database called 'Meridian' which is used to analyse data on the patient experience.

Innovation, improvement and sustainability

We had significant concerns about the service due to our concerns around record keeping, caseload management in some services, the lack of key service agreements such as for school nursing, the morale of staff working for the service and the apparent disconnect between staff and service management.

The staff we spoke with were dedicated professionals, clearly committed to providing the best possible care for children and families using their services. We spoke to a number of staff who told us that they did not develop their practice or service as they did not have time. "We are doing things on the hoof all the time", one person told us.

We saw some innovative practice including a new checklist for speech and language referrals which should be rolled out in September 2014 and will highlight children with high need who will be prioritised for treatment.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	The registered person must protect service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the regulated activity. The registered person must have regard to the information contained in the records referred to in regulation 20 **The way the Regulation was not being met:** There was a backlog of records that had been identified as requiring scanning on to the electronic record at Hessle Health Centre and Rosedale Care Centre. The operation of the systems was not effective and there was a risk that people may receive unsafe or inappropriate care. Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision 10 (1)(b) and (2)(b)(iii)

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	The registered person must have suitable arrangements in place in order to ensure persons employed are appropriately supported in relation to their responsibilities to enable them to deliver care and treatment safely and to an appropriate standard. **The way the Regulation was not being met:** Staff in a number of the children's services felt unsupported by some local and senior management within the service and their concerns were not always taken seriously or acted upon.

Compliance actions

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers 23 (1)