City Health Care Partnership CIC

BD256

Community health services for children, young people and families

Quality Report

2 Earls Court, Priory Park East
Henry Boot Way
Hull
North Humberside
HU4 7DY
Tel: 01482 347620
Website: www.chcpcic.org.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
BD256	Highland Health Centre	Health Centre	HU7 5DD
BD256	Marfleet Health Centre	Health Centre	HU9 5AD
BD256	Orchard Centre	Health Centre	HU6 9BX

This report describes our judgement of the quality of care provided within this core service by City Healthcare Partnership CIC. 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 City Healthcare Partnership CIC and these are brought together to inform our overall judgement of City Healthcare Partnership CIC.

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service l

Overall, we rated the service as good.

- During the inspection, we observed staff delivering care to children and their families in clinic settings and in their own homes. We saw staff treat children and families with dignity and respect, demonstrating kindness and compassion. We observed good relationships between staff and patients and their carers.
- The service acted on lessons learnt from safeguarding investigations. There was a safeguarding team to deliver and support training and supervision to practitioners.
- Community children's services used a range of evidence based systems and risk assessments to deliver appropriate care. There was evidence of services working with other organisations to develop competencies and deliver evidence-based practice, which supported enhanced care at home.
- The community children's nursing team were involved in a practice development project to improve care practices.
- The service used an electronic record keeping system. This provided staff with up to date information about children, including safeguarding concerns. It allowed staff to share information with other practitioners in a timely way.
- Staff had additional training opportunities, regular appraisal and were supported to re-validate their professional registration.
- Staff felt valued and listened to, and had access to supportive management.

However:

- Not all looked after children received their initial health assessment by 28 days as required by statutory guidance because of late notification of children in the looked after system from social care. This was on the corporate risk register and the provider was meeting with the local authority each month to improve the timeliness of notifications from the local authority when children became looked after.
- There were a number of information governance issues and although managers were aware of these it was not clear that an action plan was in place or that, the issues were included in the services local risk register.
- Governance processes were not fully developed for identifying, recording and managing risks, issues and mitigating actions.

Summary of findings

Background to the service

City Healthcare Partnership CIC provided services to families and children, up to the age of 19 years old, across Hull and the East Riding of Yorkshire. The services provided were health visiting, school nursing, community children's nursing and community paediatrics. Health visiting and school nursing services were restructured as 0-11 teams and 11-19 teams. CHCP CIC also provided specialist services; these were the family nurse partnership team, the looked after children team and immunisation team. The services were provided to people in their own homes, in schools, in children's centres and in community clinics across the area.

The organisation also provided respite and short-term care for children up to 18 years old with life limiting or life threatening conditions at Sunshine House. Sunshine House was inspected by the CQC in April 2016 and rated as good. Therefore, we did not visit Sunshine House at this inspection.

Children and young people under the age of 20 years made up 24 % of the population of Kingston upon Hull. 16% of schoolchildren were from a minority ethnic group.

The health and wellbeing of children in Kingston upon Hull was generally worse than the England average. Infant and child mortality rates are similar to the England average. The level of child poverty was worse than the England average (18.6%), with 31.1% of children aged under 16 years living in poverty. The rate of family homelessness was worse than the England average. 10% of children aged 4-5 years and 22.4% of children aged 10-11 years were classified as obese (CHIMAT, 2016).

During the inspection, we visited three locations. We spoke with six managers, 10 health visitors, three school nurses, one health and development practitioner, five public health nurses, four community children's nurses and one community paediatrician. We spoke with 16 families who were receiving care from the services provided. We observed practice in clinics and, with the consent of patients, in patients' homes. We examined 29 clinical records. We also held two focus groups, one for practitioners in the 0-19 team and one for community children's nurses.

Our inspection team

Our inspection team was led by:

Chair: Helen Bellaires, Non-Executive Director

Head of Inspection: Helena Lelew, Care Quality Commission

The team included CQC inspectors and a variety of specialists: health visitors, school nurse, therapists, pharmacy inspectors, registered nurses (general, mental health and learning disabilities nurses), and senior managers.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of findings

- Is it well-led?

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew. We analysed both provider-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well-led. We carried out an announced visit from 8th to 11th November 2016.

We observed how people were being cared for and talked with patients and family members who shared their views and experiences of the care they had received. We reviewed care and treatment records of children and young people who used the services. We visited services based at three locations.

What people who use the provider say

Parents and carers were positive about the care they received from the community children's services. Families felt supported by staff, and would be happy to contact them if they had any concerns about their child's health. Comments included, Lovely staff, reassuring with worries and concerns, feel listened to.

One older child we spoke with told us the service they received was 'fantastic'.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

- Ensure effective systems and processes so that lessons learnt from incidents are shared with staff groups consistently.
- Ensure governance processes are strengthened for identifying, recording and managing risks, issues and mitigating actions particularly regarding information governance issues.

City Health Care Partnership CIC

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Children's services were rated as good for safety because:

- There were systems for reporting incidents and there was evidence that duty of candour was applied where required.
- There was a safeguarding team to provide support, training and supervision to practitioners.
- The service acted upon lessons learnt from safeguarding investigations.
- Records included appropriate risk assessments and evidence of individualised care planning.
- The service had systems to assess and respond to patient risks that included effective handover of care between teams and a pathway to follow if a child did not attend appointments.
- There were systems to ensure staffing levels were safe. Staffing was managed appropriately so that caseloads were covered. There were two vacancies for community paediatricians and the service was trying to recruit, locum staff covered these gaps.
- The majority of staff had completed mandatory training in most areas.

However:

- There were a number of information governance incidents and although managers were aware, of the issues, it was not clear whether an action plan had been developed or that the issues were included in the services local risk register.
- Although incidents were reported, not all staff had a understanding of what needed to be reported or the outcomes.

Detailed findings

Safety performance

Good

Are services safe?

- There had been no never events in children's community services reported. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The organisation was involved in three ongoing serious case reviews, relating to harm to children and young people. Serious case reviews are multi agency investigations, which occur when a child has suffered serious harm or death. They provide lessons to be learned for services involved in promoting the health and well-being of children.
- The organisation was involved in one serious incident investigation. This was a joint investigation across midwifery, community and acute services, which was underway at the time of inspection.

Incident reporting, learning and improvement

- All incidents were reported through an electronic reporting system. Data provided showed 57 incidents had been reported in children's services, between October 2015 and September 2016. Incidents were graded by level of harm. There was one catastrophic incident related to an unexpected child death. Of the incidents graded as no harm and negligible, most frequently they were reported as information governance issues. Communication and information governance issues accounted for 45% of incidents overall. Senior managers were aware that this was a concern, but it was not recorded as a risk for the service, and no actions were in place**.**
- Staff told us they were trained to use the reporting system but there were very few examples from staff as to when they had used the system. Staff were limited in the examples they could provide about what was to be reported.
- We saw an example of an action plan following a serious case review. The recommendation was a change in the way information was shared to practitioners about domestic violence. We saw evidence of this during inspection on client records.

Duty of Candour

- The majority of staff had knowledge of duty of candour and spoke about the need to be open and honest with patients and their carers.
- The provider had a policy on duty of candour and information on the subject was included in the mandatory information governance training. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- During the reporting period from 1st April 2015, there were eight incidents reported within children's services that required a duty of candour response, and evidence was provided.

Safeguarding

- The organisation had a safeguarding children policy, published September 2015. The organisation provided an annual report for safeguarding children, 2015, reporting on the activity and outcomes of safeguarding related work and actions for the following year.
- There was a safeguarding children team. The team consisted of a named nurse for safeguarding children, four specialist nurse practitioners, a safeguarding trainer and three administrative staff. The named nurse also acted as the designated nurse for looked after children.
- The local clinical commissioning group provided medical provision for the safeguarding team.
- There was an established process of referrals to social care, so the safeguarding team had an oversight into referral rates and individual cases. The information was used to support practitioners in the referral process and to improve the quality of referrals. This was an action learning point from a serious case review.
- The team had a specialist role in training, supervision, advice giving and representing the service on specialist panels such as MARAC (multi-agency risk assessment conference).
- The team provided level 2 and 3 training for staff, in line with the Royal College of Paediatrics and Child Health intercollegiate document.
- Staff we spoke with said they had received safeguarding level three training, which is mandatory for staff working with children.

Good

Are services safe?

- Safeguarding training across levels 1, 2 and 3 had a target of 80%. All practitioners working with children who assessed care needs must be trained to level 3. Training compliance across children's services as of October 2016 was:

Level 1 – 93%

Level 2 – 85 %

Level 3 – 82%

- During inspection, staff we spoke with had received safeguarding training at the level appropriate to their role. They had knowledge of female genital mutilation and child sexual exploitation. We saw learning on these topics as part of safeguarding training modules.
- Staff across children's services received quarterly safeguarding supervision, in line with national policy recommendations. Staff could also access additional supervision from the safeguarding team.
- Safeguarding supervisors had monthly meetings, these highlighted issues and learning to feedback to practitioners. For example, sharing the outcomes from investigations.
- Staff were aware of the escalation process if they felt someone was at risk of harm.

Medicines

- The organisation had a system and standard operating procedure to manage the cold chain to ensure the safe storage and transportation of vaccines to schools.
- Health care staff to enable them to give medication and immunisations without a prescription used patient group directives (PGD). We looked at a sample of PGDs used by school nurses and community children's nurses. These were up to date with current best practice and signed by staff using them.
- Health visitors and school nurses were independent prescribers and able to prescribe from a pre-determined and approved list of medicines. However, some staff we spoke with did not use their prescribing skills. One staff member told us this was because they lacked confidence in prescribing. School nurses providing immunisations and contraception did this by using patient group directives, rather than individual prescriptions.

Environment and equipment

- We visited one location where children and their families accessed services. There was good access for patients with disabilities, and children in pushchairs. The environment was clean and well presented.
- Health visitors had their own infant weighing scales, which they took to clinics and on home visits. These were calibrated every six months and we saw in date test stickers on equipment.
- The community children's nurses could evidence how often equipment used in patients' homes was serviced and when medical servicing was required. The medical assets list was audited monthly.
- Electrical equipment was portable appliance tested, for safety. Staff knew how to report faulty equipment.
- The adolescent team ran weekly drop in clinics at secondary schools. We attended one drop in which was held in a room next to a staff office with a connecting door. Conversations were heard from the other room and we raised a concern at the time about the confidentiality of the room for young people.

Quality of records

- The organisation used an electronic based system for record keeping.
- We looked at 29 records across children's services. Records included appropriate risk assessments and evidence of individualised care planning and had been completed within expected timescales. However, staff we spoke with said they often completed records in their own time to ensure they met the nursing and midwifery council record keeping standards.
- Records were audited as part of the quality benchmarking undertaken across the service. The benchmark target was 85%. The 0-11 service was benchmarked at 94% compliance, family nurse partnership team at 95%, and the 11-19 team was 93% compliant.
- Safeguarding flags and indicators of increased levels of care were in use on the electronic system. These highlighted increased levels of risk to staff, about the patient.

Cleanliness, infection control and hygiene

- We observed staff using alcohol based hand gel when they visited patients' homes, however we observed not all the staff adhered to arms bare below the elbow guidance.

Good

Are services safe?

- We observed staff to clean weighing equipment before and after use.
- Personal protective equipment (gloves and aprons) were used and disposed of appropriately.
- We saw toys in a clinical area, they appeared to be physically clean, but there were no cleaning schedules available.
- Infection prevention and control was monitored as part of the quality benchmarking. The target for infection prevention and control compliance was 85%. The 0-11 service achieved 93% compliance and was the only team to provide data for infection prevention and control.

Mandatory training

- There was a programme of mandatory and statutory training available for all staff, which covered areas such as moving and handling, basic life support, safeguarding, information governance and infection control.
- Mandatory training rates were variable across the modules, with an overall representation of 88% of staff in children's services completing training as of October 2016. The organisations target for mandatory training was 80%. Areas, which were below targets included basic life support (every two years) 74%, moving and handling L2/L3 (every two years) 61%, fire safety awareness (annual) 78% and anaphylaxis (every two years) 79%.
- Staff had access to a training matrix, which provided them with early warning when training was due.

Assessing and responding to patient risk

- The 0-19 service had a duty system in place to take calls from the public and other professionals. The call would be dealt with at the time with appropriate advice and information, or triaged and allocated to a member of the health visitor or adolescent team for action or delegation to a suitably qualified member of the team.
- Staff used a range of risk assessment tools to assess and manage individual risks such as, maternal mood assessments, safety assessments, and pressure areas.
- The family nurse partnership undertook DANCE (Dyadic Assessment of the Naturalistic Caregiver Experience) assessments. This allowed the practitioner to assess caregiver and child interactions and provide interventions to promote outcomes.
- Health visitors and public health nurses undertook a holistic assessment of children, which enabled them to identify risks and protective factors.
- There was a process of handover of care between the 0-11 and 11-19 teams, for children requiring more than universal service level of care.
- The service had a pathway to follow if children did not attend appointments, and were thought to be 'lost' to the health care system. The pathway included communication with GP's, schools, social services and other health care providers.

Staffing levels and caseload

- The 0-19 service had been reconfigured to meet the commissioner's strategy of a seamless service. There was a 0-11 team consisting of health visitors and public health nurses (previously band five school nurses). The 0-11 service caseloads were 405 children per full time health visitor, which was in line with national recommendations.
- The 11-19 service was re-branded as the adolescent team. The team consisted of qualified school nurses practitioners, public health nurses, the looked after children team and the immunisation team. This team also provided care to children not in education.
- There was a public health team. This team was led by a band 6 school nurse and were staffed by health and development practitioners (previously nursery nurses). Their role was to complete the national child measurement programme, audiology testing, hand hygiene and sexual health education to all children in schools and special schools.
- The family nurse partnership team had caseloads of 20 families, per practitioner, against a commissioned 25 families.
- The children's community nursing team had recently become an integrated team of 18 qualified and support staff. They worked six days per week to provide nursing care to children in their own home and in clinics.
- Vacancies and sickness levels were below 5% in the 0-19 service.
- There were two whole time equivalent vacancies for community paediatricians. The organisation had been trying to recruit to these posts for two years. They had been trying to recruit as a joint post with the local NHS hospital as a more attractive position. However, the recruitment was still ongoing. Locum paediatricians covered the gaps in paediatric clinics.

Good

Are services safe?

Managing anticipated risks

- A business continuity/resilience plan was in place for the 0-19 services. It demonstrated the children's services plan to respond to incidents and disruptions in order to continue their operations at an acceptable level, for example adverse weather conditions, activity peaks and staff shortages.
- The provider had a policy to protect staff who may be lone workers. Staff had mobile phones with a lone working application. This was to be activated on each home visit; however, staff told us they did not use it if they were going to a visit where the family were known to the service.

Good

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

Children's services were rated as good for effective because:

- There were up to date policies and guidance accessible to all staff.
- Evidence based systems and risk assessments to deliver appropriate care were in use. The service worked with other organisations to develop competencies and deliver evidence based practice.
- The organisation held Level 3 UNICEF baby friendly accreditation.
- The organisation supported staff development, to promote staff skills and enhance services provided.
- Staff had good access to records and shared information about service users in a timely way.
- Staff had good knowledge of consent to treatment processes.

Detailed findings

Evidence based care and treatment

- We saw a range of policies and care pathways, which were accessible to staff, on CHCP CIC intranet. We reviewed 17 policies and pathways, which were all in date and reflected current practices.
- Community children's nursing team also had online access to the Royal Marsden Manual of Nursing Procedures, which are nationally recognised and clinical guidelines from a local hospital trust. The team looked after children who received treatment from the hospital, so this promoted continuity of care and good practice.
- Health visitors were delivering the Healthy Child Programme (0-5) to families on their caseload. This was an evidence-based programme focussed on a universal preventative service. It provided families with screening, health and development reviews, supplemented with advice about health, well-being and parenting.
- The development reviews for 3-4 months, 8 months to 1 year olds and 2-2.5 year olds were undertaken using Ages and Stages Questionnaire (ASQ-3). This was a research based developmental screening tool, which assessed children's physical and emotional development to identify any delays in a child's development.
- The public health team carried out the national child measurement programme in accordance with government guidelines. Children and families could be referred into a healthy weight programme, which was also provided by City Health Care Partnership.
- Family nurse partnership was a evidence based and preventative programme for vulnerable, first time young mothers. It was delivered from pregnancy until the child was two years of age. The service was delivered within a licenced programme, which was regularly audited, to ensure staff were delivering care within the well-defined and structured service model. This ensured compliance with national family nurse partnership guidelines.

Nutrition and hydration

- The organisation held Level 3 UNICEF baby friendly accreditation. The UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast-feeding and promote parent/infant relationships.
- There was a full time lactation consultant. Their role was to support staff training on the UNICEF standards, and to support families with breast feeding issues in order to improve the rates of breast-feeding.
- We saw staff provided information to parents about feeding; this was in line with national guidelines.
- Community children's nursing staff had access to dieticians for support with specialist feeding.
- 10% of children aged 4-5 years and 22.4% of children aged 10-11 years were classified as obese, which was worse than the England average of 9% and 19% respectively. The teams could refer children and their families into the healthy weight programme, which was provided by the organisation.

Patient outcomes

Good

Are services effective?

- We saw evidence that patient needs were assessed before care and treatment started and there was evidence of care planning. This meant that children and young people could receive the care and treatment they needed.
- Health visitor key performance indicators were based on commissioners' requirements and were quantitative, relating to patient contacts. The evidence for the contacts was measured from the electronic record system.
- A lower percentage of mothers initiated breastfeeding compared with the England average of 74%, with 66% breastfeeding. By six to eight weeks after birth, 29% of mothers continue to breastfeed, which was also lower than the England average of 44%. The service had a full time lactation consultant to support staff and families, in increasing breastfeeding rates.
- As of March 2016 in Hull, 86% of families received new birth visits from health visitors, within 14 days of birth. 81% of families received a follow- up visit by the time their child was eight weeks old. 93% of children received a 12-month review in the month of their 1st birthday. 89% of children received a 2-2.5 year review. There was no data available to compare these statistics against the England average.
- Uptake of primary immunisations in the year 2015/16, were 97%. This was above the England average of 94%. Immunisation rates for MMR were comparable with the England average at 97% for first dose and 91% for the second dose uptake.
- Flu immunisation uptake was 59%. Uptake of the HPV vaccine was 79% for first dose and 72% for second dose, which was below the England average of 86% in 2013/14.
- Family Nurse Partnership outcomes were monitored and measured, and the service undertook quarterly reporting. The September 2016 report demonstrated that the service was working at 76% capacity. Of clients referred to the family nurse partnership programme, only 59% enrolled on the programme. The indicator for enrolment of eligible clients was 75%. The indicator for clients to be enrolled by the 16th week of pregnancy was 60%, and the team achieved 56%. There were no actions with the report as to how the service may make improvements.
- There was no audit information available. Staff told us they were not involved in auditing the effectiveness and quality of their services.
- The organisation undertook some benchmarking reports against five Essence of Care Standards (2001) for the 0-11 service. These measured compliance for record keeping, communication, care environment – which included infection control, promoting health and well-being, privacy and dignity, and safeguarding patients. However, the services did not provide data for all the benchmarks. For example, family nurse partnership had only benchmarked against record keeping. The benchmarks that had been completed met the 85% target.

Competent staff

- The appraisal rate for staff was 88%. The target was not provided.
- The children's community nursing team developed competencies in partnership with a local hospital trust. Staff were able to access training materials online, attend teaching sessions and there were opportunities to work in the trust. For example, to develop specialised skills in oncology, this promoted opportunities for children to receive treatment at home.
- There was a practice development lead for the 0-19 service.
- There was a preceptorship programme for new members of staff.
- All the staff we spoke with were positive about the training opportunities available. A comment received was 'the organisation is generous with time and funding for training'.
- The provider had a policy to support professional re-validation for staff.

Multi-disciplinary working and coordinated care pathways

- We observed staff working together with other agencies to meet the needs of children and families, for example, the local authority, children's centres and schools. Practitioners acted as link staff between GP's, schools, children's centres and nurseries.
- The health visitors were working towards joint assessments with nurseries for two and three year olds to promote readiness for school.
- The adolescent team had developed good working relationships with agencies to ensure looked after children were prioritised.

Referral, transfer, discharge and transition

Good

Are services effective?

- Children and young people were referred by all staff in the 0-19 service for assessment and treatment to the specialist services. Specialist treatments, for example paediatric therapies, were provided by a different organisation. Staff told us that sometimes there could be a breakdown in communication causing delays in children accessing the right care.
- We were told of examples were there had been problems with communication between midwives and the 0-11 teams. Community children's nurses told us of examples where there were difficulties in transferring children with long-term conditions into adult services. There was a transition pathway in place.

Access to information

- The use of electronic record keeping allowed practitioners to share information, with consent, to other professionals, for example, GP's. The service had access to information when children attended emergency departments.
- The use of mobile technology enabled staff to have access to patients' records in a timely manner. Staff could have direct access to records and undertake record keeping in patients' homes, however staff reported difficulties in IT connectivity at times, which could led to delays in record keeping.
- All staff had access to the organisational intranet where policies and procedures were stored.

Consent

- We were told children and young people were involved and supported by staff in making decisions about their health care and treatment.
- The 0-19 staff demonstrated good knowledge of relevant legislation about consent, for example applying Gillick competencies and Fraser guidelines.
- We saw consent to share information documented on patients' records.
- Mental Capacity Act training was not part of the mandatory training programme, but staff demonstrated awareness of the Act.

Good

Are services caring?

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

Summary

Overall we rated children's services as good for caring because:

- Parents and carers were positive about the care they received from the community children's services.
- People we spoke with told us they were treated with compassion, dignity and respect. They were provided with information about their child's care, in a way they could understand, and were given the opportunity to contribute to their care plan and treatment.
- Staff provided information of other services to enhance care.
- Children and families were provided with emotional support from the services. The staff had the ability to refer children to appropriate health services such as the mental health team if more specialised support was required.

Detailed findings

Compassionate care

- We observed staff delivering care to children and their families in clinic settings and in their own homes. We saw staff treat children and families with dignity and respect at all times. They were sensitive to the children's needs, demonstrating kindness and compassion. We observed good relationships between the staff and patients and their carers.
- We observed staff respond to a distressed child, during a phlebotomy clinic, with sensitivity and compassion. The staff explained things calmly to the parent and provided distraction to the child in order to undertake the procedure successfully.
- Parents gave us positive feedback about the services. About the children's community nurses, one parent said 'they provide a good service and no problems getting appointments'.
- Friends and family test data was gathered through an electronic device during patient contact. In response to the question would you recommend the service to friends and family community children's nursing received 100% would be 'extremely likely' to recommend from 32 responses. Out of 57 responses, 93% would be 'extremely likely' to recommend the community paediatric service. Out of 56 responses, 60% would be 'extremely likely' to recommend the health visiting service and 42% of 137 responses to school nursing would be 'extremely likely' to recommend the service to a friend or family.

Understanding and involvement of patients and those close to them

- Young people were supported in making decisions, for example, to seek advice from GP's. We saw staff speak to young people sensitively about sexual health needs and referrals could be made to the adolescent sexual health nurses.
- Staff were passionate about putting the child first. We saw staff interact with children in a way that was appropriate to the child's age and level of understanding.
- We observed home visits. The staff developed a good rapport with parents. They explained things clearly and checked that there was understanding. Staff demonstrated understanding and flexibility to meet family needs when planning care. A parent told us they felt 'much supported by the health visitor in my choices on how to raise my family'.
- Staff acknowledged that dads were not always involved in the care planned. One member of staff was undertaking research in this area.

Emotional support

- Children and families were provided with emotional support from the services. The staff had the ability to refer children to children and adolescent mental health services if more specialised support was required.
- Parents told us staff communicated effectively with them. One parent told us they 'felt reassured and listened to'.
- Staff were aware of the pathway to manage post-natal depression, which reflected national guidance. There were plans to provide more training for staff in mental health.
- We saw how staff provided information to families about other services, which could offer support, for example, services at children's centres and voluntary organisations.

Good

Are services responsive to people's needs?

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

Summary

Children's services were rated as good for responsive because:

- The organisation had responded to commissioners in developing a service, which provided greater continuity of care for children and families by the integration of services.
- Staff worked with other agencies to meet the needs of vulnerable young people.
- A community paediatrician saw children within the time set by national standards.
- Staff were aware of the cultural diversity of the community they worked in and most staff had received training in this area.
- There were processes for managing complaints and learning from complaints.

However:

- Not all looked after children received their initial health assessment by 28 days as required by statutory guidance because of late notification of children in the looked after system from social care. This was on the corporate risk register and the provider was meeting with the local authority each month to improve the timeliness of notifications from the local authority when children became looked after.

Detailed findings

Planning and delivering services which meet people's needs

- Children's services were provided in patients' homes, as well as in local clinics, schools and children's centres that were accessible to patients.
- There were weekly drop in clinics at secondary schools to provide opportunities for young people to access a healthcare professional in a confidential setting.
- The 0-19 service had recently been re-configured. Teams, which included health visitors and public health nurses, provided care for children up to 11 years old. This was to provide continuity of care for families, for example, families with older children who were receiving safeguarding support only had to work with one team of practitioners, rather than both health visitor and school nursing teams.
- The organisation also provided a service to schools in addition to the commissioned services. Schools paid directly for the service of the school health plus practitioners, to provide drop in services and health advice/sessions.
- The public health team participated in the 'You're Welcome' initiative, which was the Department of Health's quality criterion for young people friendly health services.

Equality and diversity

- All services we spoke with were aware of the diverse needs of the population and planned for interpreter services where needed. Staff had access to a face-to-face translation service.
- Some staff working in the public health team had trained in Makaton, a language programme using signs and symbols to help people communicate. This allowed them to engage better with children who had communication difficulties.
- Staff were aware of the cultural diversity of the community they worked in. Equality and diversity training was part of mandatory training and 99% of staff in care group 2 had completed as of October 2016.
- Staff reported they had access to equipment to meet patients' needs.

Meeting the needs of people in vulnerable circumstances

- The public health team and the adolescent team could refer children to the specialist sexual health team for young people. The consultant in that team specialised in the care of young people and those with learning disabilities.
- The public health team provided sexual health education for children, in mainstream schools and special schools. They had understanding of the

Good

Are services responsive to people's needs?

indicators of female genital mutilation and child sexual exploitation; they worked with the police and social services to help protect young people in vulnerable circumstances.

- The annual report for looked after children 2015/2016 outlined the scope and needs of looked after children in Hull. Between April 2015 and March 2016, 53% of children received an initial health review within the statutory requirement of 28 days and 80% of review health assessment. The report recommended that work should be undertaken to improve the timeliness of notifications from the local authority when children became looked after. This was on the risk register for the service.

Access to the right care at the right time

- Community paediatricians accepted referrals from health professionals, schools and social services. There was a referral criterion and a community paediatrician triaged referrals. Paediatricians saw children who had medical conditions and developmental delay and were meeting national indicators of 18 weeks. In the three months prior to inspection, the time from initial referral to treatment was nine weeks.

Learning from complaints and concerns

- Eight complaints were received in the last 12 months before the inspection across the children's services. Complaints were responded to within 40 days. Managers told us learning from complaints was cascaded through team meetings. However, staff we spoke with were not able to provide examples of learning from complaints.
- We asked families if they knew how to make a complaint. They told us they were not sure of the process of making a complaint, but they would be happy raising their concerns to the staff visiting them.

Requires improvement

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

Children's services was rated as requires improvement for well-led because:

- Staff reported that when issues were highlighted through the lines of governance, responses were slow. Action plans from meetings did not clearly identify lines of responsibility and timescales. A process for sharing information amongst teams was not fully embedded.
- The local risk register was not fully developed for identifying, recording and managing risks, issues and mitigating actions.

However:

- The service had a clear strategy in its aim to integrate services and work in alignment with the Local Authority. Staff were engaged in the development of the children's services strategy.
- Staff were positive about the support received at service level and reported senior management to be visible at service level. Staff told us they could communicate directly with the chief executive if they had concerns.

Detailed findings

Leadership of this service

- The chief executive was the lead for children on the executive board.
- Staff were positive about the support received at service level and reported senior management to be visible at service level. Staff told us they could communicate directly with the chief executive if they had concerns.
- Monthly staff meetings were introduced in response to the staff survey and were reported to be well attended.
- A 0-11 newsletter for staff had just been developed to promote communication about the service strategy.

Service vision and strategy

- The provider had a strategy for children services within the care group directorate. The vision for the directorate was to provide an integrated model of care that provided a seamless service and to work closely with Local Authority strategies.
- There had been a programme of engagement with staff to share the strategy of the organisation. We were given examples from staff about how they had been involved in the development of the new teams of health visiting and school nursing.
- Organisational values were service and excellence, equality and diversity, creativity and innovation and co-operation and partnership. Staff were able to articulate some of the values.

Governance, risk management and quality measurement

- Care Group 2 managed the service. The care group provided a monthly governance report. This provided oversight of complaints, serious incidents and risks.
- The service had two risks on its risk register; these were reflective of issues highlighted on inspection and from the data. Vacancies within the community paediatric medical team had been on the register for over two years. The service leads were mitigating the risk by using locum medical cover and had an ongoing recruitment drive in place. The service leads reported they were only just starting to look at alternative ways of working to provide community paediatric medical cover, for example, the introduction of advanced nurse practitioners to support looked after children initial health assessments.
- There was however an independent and ongoing work stream to explore alternative means of filling the medical vacancies. There had initially been a requirement by commissioners to replace medical staff with medical staff. This has been resolved and CHCP continue to explore proactively opportunities to skill mix at the time of inspection.
- Meeting the standards for looked after children's initial health assessment was being mitigated by providing locum medical cover. The service leads and the community paediatrician spoke of the delay in communication from the Local Authority of a child becoming looked after and requiring a health assessment within 20 days, being the main concern for not meeting this outcome.

Requires improvement

Are services well-led?

- There was a lack of clinical audit being undertaken to measure quality of services provided.
- Senior managers reported to the senior management team meeting. Issues of concern were escalated to the safety and quality forum. Staff were clear about the lines of escalation; however, they reported that responses to issues escalated were slow.
- The family nurse partnership had no action plan as to how it would address the shortfalls in meeting the national programme standards.
- We reviewed minutes from the safety and quality forum. Issues discussed included incidents, complaints, safeguarding and medicines management. However, it was not clear from the minutes what the outcomes were and how actions would be taken forward and cascaded.
- We reviewed minutes from the integrated safeguarding group meeting. There were notes of discussions and actions, with delegated responsibility. However, there were no timescales applied for the actions to be completed.
- We saw a sample of team meeting minutes across the services held between August 2016 and October 2016. Minutes were variable across teams regarding standing agenda items, and how actions were recorded. There was a lack of timescales applied to actions across the team meetings.

Culture within this service

- We were told 'children are at the heart of everything we do' by staff. Staff spoke with passion and pride about the care they delivered.
- Staff felt communication from the executive board had improved and felt listened to and valued.
- The 0-19 service had introduced restorative supervision as part of their team meetings. This practice was aimed at listening, supporting and challenging practitioners to improve their capacity to cope, especially in managing difficult and stressful situations at work.
- The community children's nursing team told us of a recent 'team away day' in which the newly re-configured team were given time to build relationships and a team spirit.

Public and Staff engagement

- Staff were working towards involving young people in the development of services through a youth forum. We saw an example of how information leaflets had been developed and presented for feedback from young people as to which best met their needs.
- Young people had been involved in some recruitment of the adolescent team in the past. Senior staff told us they were hoping to build on this and involve young people on a more consistent basis in service development.
- There were plans to increase public engagement using technology; this was a requirement of the service contract.
- We did not see evidence that young people had contributed ideas to the re-configuration of the service. Senior managers told us the public were informed of the changes to service delivery once the re-configuration had been finalised.
- Staff had been well informed of the re-design of the 0-19 service; some staff had been 'change champions'. The organisation had an employee engagement strategy and plan for 2015/16.

Innovation, improvement and sustainability

- The service had been re-designed to provide a sustainable service, meeting the needs of commissioners.
- Community children's nursing team were taking part in a practice development project in partnership with Hull & East Yorkshire Hospital trust. This involved the clinical trial of using salt for treating over-granulation of tissue surrounding gastrostomy sites.