Care Quality Commission

York Teaching Hospital NHS Foundation Trust

RCB

Community health services for children, young people and families

Quality Report

Tel: 01904 631313
Website: www.yorkhospitals.nhs.uk

Date of inspection visit: 17–20 March 2015
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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)
RCBL8	Malton Community Hospital		YO17 7NG
RCBXD	Selby War Memorial Hospital		YO8 9BX

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good

We found that services were effective and that staff were caring and responsive. In particular, we found in the 'responsive' domain that there were very good systems in place to provide translation services for people whose first language was not English, and sign language interpretation services for people who were profoundly deaf.

The 'safe' domain has been rated as requiring improvement. There were concerns raised with us that the design and environment of the contraceptive and sexual health service clinic at Monkgate in York did not allow for full confidentiality. We also found that 10,000 records were not completely secure at one of the trust's locations. Staff told us that they were concerned that there was a backlog of paper documents resulting from a lack of scanners in some locations.

There was concern among school nursing staff that there was not enough flexibility built into staffing numbers and arrangements.

Overall, we found that the service was well led, although there was some concern from staff about a lack of support from senior managers within the school nursing and health visiting service.

Summary of findings

Background to the service

Community health services for children, young people and families included a range of services delivered to people in the City of York and in parts of North Yorkshire. Core services included health visiting, school nursing, and a contraceptive and sexual health service. These services were complemented by specialist teams. A health visiting service was provided for the City of York, Easingwold and Selby. At the time of the inspection, a school nursing service was provided for the City of York and Selby. Since April 2015, the school nursing service for Selby has been provided by another organisation.

Children and young people under the age of 20 make up 21.7% of the population of York. The health and well-being of children, and the level of child poverty, is generally better than the national average. In 2012/13, children were admitted for mental health conditions at a similar rate to that of England as a whole. However, the rate of inpatient admissions during the same period for self-harm was higher than the England average.

Our inspection team

Our inspection team was led by:

Chair: Stephen Powis, Medical Director, Royal Free Hospital

Team Leader: Adam Brown, Care Quality Commission

The team included a CQC inspector and a variety of specialists including a health visitor, a children's community nurse and a school nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive acute 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 17 and 20 March 2015. During the visit we spoke with a range of 60 staff who worked within the service, including nurses, doctors and therapists. We spoke with eight family members, including young people who used the services. We observed how people were being cared for, talked with carers and/or family members, and reviewed more than 15 care or treatment records of people who used services. We met with people who used services and carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider say

People we spoke with during the inspection were complimentary about the services and told us that staff were caring and knew how to meet the needs of children and young people.

We reviewed patient surveys from two services: the community eczema service and the contraceptive and sexual health (CASH) service. Responses included that parents thought they were well informed about their child's eczema and that people found the CASH telephone service acceptable.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider must ensure that patient records are fully secured when stored.

The provider should ensure that confidentiality can be maintained within the environment of the contraceptive and sexual health (CASH) service clinic at Monkgate in York.

The provider should ensure that there is enough flexibility built into staffing numbers and arrangements for school nursing staff.

York Teaching Hospital NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

There were concerns raised with us that the design and environment of the contraceptive and sexual health (CASH) service clinic at Monkgate in York did not allow for full confidentiality. It is important that CASH clinics have facilities which allow the highest levels of confidentiality to be observed. We found that school nursing staff working in a school did not follow accepted medicines management practice: medicines were administered without a prescription, and medicines information was transcribed from the labels on drug boxes rather than from a prescription.

Staff told us that they were concerned that there was a backlog of paper documents resulting from a lack of scanners in some locations. For example, there was a backlog of information relating to the accident and emergency department (A&E) and GP referrals, which could lead to children, young people and families waiting an inappropriate length of time before being seen.

There was concern among school nursing staff that there was not enough flexibility built into the staffing numbers and arrangements to ensure appropriate cover for sickness and holiday periods.

There were systems in place for the reporting of incidents, and learning from incidents. There were also systems and procedures for the management of safeguarding issues, although some staff told us that they were not up to date with their safeguarding training.

Detailed findings

Incidents, reporting and learning

- Staff we spoke with told us that they knew how to report incidents using the online Datix reporting system, which

Requires improvement

Are services safe?

was part of the trust's intranet. Staff told us that, although they received feedback on incidents they themselves had reported, there was less consistency in feedback from incidents that occurred in other areas of the directorate or the trust.

- We reviewed a critical incident investigation report that had been prepared in February 2015. This described errors that may have occurred in the care of a child who was initially assessed following home visits in November 2010 as being of high risk, and therefore coming under the 'universal partnership plus offer'. This higher category would have necessitated an increased number of visits and a greater level of service involvement in the care of the child, including a multi-agency approach.
- However, this level had been reduced to the basic level of the 'universal offer', although there was no record of why this had occurred. As a result, the greater needs of the child were brought to the service's attention only after police involvement with the child's family. Health visiting and safeguarding investigations showed that the child should have remained on the high-risk 'universal partnership plus offer'.
- The root cause analysis undertaken by the service described human and systems errors as being behind the sequence of events that had led to the child not receiving the level of service they should have received.
- Recommendations were made that fail-safe systems should be made available within the 'SystmOne' electronic patient record, a 'look back' exercise should be undertaken, managers should be aware of families assessed as being of higher need, and the lessons learned should be disseminated. At the time of the inspection, the actions resulting from these recommendations were awaiting completion; the timescales for completion extended to June 2015.
- The service used a "Child Health Risk Register", that contained 14 areas of risk.

Cleanliness, infection control and hygiene

- When we accompanied staff on home visits, we observed them observing cleanliness, infection control and hand hygiene procedures.
- We found that the Contraception and Sexual Health (CASH) service had audited compliance with hand hygiene, 'bare below the elbows' and glove use between April 2013 and March 2014. The audit found that compliance for doctors, nurses and healthcare assistants was 100%, apart from three occasions when it slipped to 94%.

Maintenance of environment and equipment

- We saw evidence that the service undertook portable appliance testing (PAT) and equipment had been appropriately checked.
- We found no further areas of concern with regard to the maintenance of the environment or equipment.

Medicines management

- We found evidence of poor medicines management at a special school in York that was covered by the school nursing service. Here, we observed nursing staff transcribing medicines information from the labels on the drug bottles to the medication record. The appropriate method would be to transcribe the information from a prescription. Medicines were also administered without a prescription. Staff told us that they had been using this practice for some time. This was reported to the trust so that it could take action.
- Human papilloma virus (HPV) and influenza (flu) vaccines were collected from the trust pharmacy, and any that had not been used were returned to the pharmacy. A log was kept to ensure compliance with this procedure. Audits were undertaken of the provision of the flu vaccine; these included an evaluation of documentation, adverse reactions and refusals to accept the vaccine, with reasons noted.
- Patient group directions (PGDs) were used by the CASH service. These were supported and signed off by medical staff and by a clinical mentor for nurse prescribing, who electronically audited the PGDs in liaison with the trust's pharmacy service.

Safeguarding

- Staff told us that the design of the CASH clinic in Monkgate made full confidentiality and disclosure difficult which could impact on safeguarding of children and young people. This was due to a lack of sound proofing. We were told that the trust was aware of these issues and was in the process of taking action to remedy them.
- Health visiting and school nursing staff were trained to level three in children's safeguarding; this is the highest level. This was also the case for staff who worked for the

CASH service. Staff we spoke with told us that they were aware of how to report and escalate safeguarding concerns. They also told us that they had easy access to social services safeguarding teams, who they could phone for advice.

- Safeguarding supervision was available on a regular basis for all staff. It could also be accessed on request in order to discuss individual cases.
- We accompanied school nursing staff to a children's safeguarding case conference where we observed them engage in a meaningful, professional and knowledgeable way with colleagues from social services and other agencies.
- When visiting a CASH clinic, we observed a potential safeguarding issue. When we reported the issue to staff, they took immediate action through the trust's safeguarding procedures and contacted the responsible authorities, including social services.
- We also found that the CASH service used a 'sexual exploitation tool book'. This included a pro-forma that was completed for all people under the age of 18 and that took into consideration Gillick competency and Fraser guidelines (see Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security [1984] QB 581).
- We spoke with school nursing staff who described how they had identified an example of sexual exploitation of a child and had assisted in them being moved to a place of safety, in coordination with a multi-agency safeguarding team.
- Staff we spoke with at the Applefield School told us that 10 school nurses had not received updates to their safeguarding training.

Records systems and management

- The service was in the process of transferring hard copy paper records to a new electronic database, called SystmOne. Implementation of this system was at different stages in the different locations and within the various groups in children and family services. There were therefore different levels of knowledge among the staff we spoke with.
- There was also a concern that there was a backlog of paper documents resulting from a lack of scanners in some locations. For example, there was a backlog relating to A&E and GP referrals, which could lead to patients and families waiting an inappropriate length of time before being seen. Staff we spoke with told us that there was not enough guidance on how to record information using the templates on SystmOne and that they felt the changeover process had been managed badly.
- The ultimate aim of implementing SystmOne was to create an electronic clinical records database that could be shared with a greater number of partner organisations and clinicians. However, at the time of the inspection, the required consent process for the electronic sharing of records had not been undertaken and therefore information was not being shared across the health and social care community.
- We reviewed information on SystmOne, including data relating to the health visitors' 'six to eight week assessment'; this is part of the 'universal offer' provided to young children. This included ongoing support with breastfeeding and the assessment of maternal mental health.
- Health visiting staff we spoke with told us that they would make notes, often in their work diaries, when they met people in their homes. They would then put this information on the electronic patient record when they got back to their base.
- We found that school nurses carried confidential documents in their personal bags when walking the short distance from their base to multi-agency safeguarding strategy meetings. This created a risk, given the highly confidential nature of the documents being carried. We spoke with a senior manager at the trust who told us that they were in the process of obtaining secure bags to transport the documents.

Lone and remote working

- Staff who worked outside in the community were in the process of being supplied with electronic alarms; these automatically connected to a security control centre when activated. All staff who worked remotely ensured that colleagues knew where they were going when they left the office. They also always carried mobile phones with them. They also told us that they would risk asses the properties they were going to in order to maximise their health and safety. They did this using a 'community site risk assessment form' that was stored on the trust intranet.
- However, we also became aware of an issue of concern when we were informed that staff would accompany young people travelling out of the area who were having terminations of pregnancy. They would do this in their

own vehicles as well as on public transport. There was no official policy or procedure for this practice, which presented a potential risk to the young people and the staff.

Assessing and responding to patient risk

- Holistic assessments of children's needs were undertaken by the service. Staff followed guidelines for completing the community child health record, the family membership form and the main health record. These included a holistic assessment of a child's needs and associated risks.
- Staff explained to us that this was part of the common assessment framework (CAF), which they were in the process of replacing with the family early health assessment (FEHA). This was part of Working Together to Safeguard Children (HM Government, March 2013).

Staffing levels and caseload

- We spoke with staff in the health visiting service who told us that they felt there were sufficient staff available to meet the needs of the service. They said that this was also the case when there was staff sickness.
- However, school nursing staff we spoke with told us that staffing levels left little flexibility for covering sickness or holidays, or for managing what they felt was an excessive workload. They told us that they would work extra hours to cover holiday absences. We also found evidence of staff filling out risk reports in the Datix system when there was not enough cover. One member of staff we spoke with told us: "We feel that we are reactive rather than proactive, and there is very little early intervention due to workload demands."
- Within the health visiting and school nursing teams, we found that weekly meetings were held to organise the allocation of team members to cases. Following a health visitor implementation plan, the numbers of health visitors in areas of high deprivation had been increased.
- Health visiting staff told us that they had an individual caseload of about 300 for each whole-time equivalent (WTE) team member.
- We were informed that, within the CASH service, there were 153 hours of vacancies (each week) on hold until July 2015 while a new service tender was being developed.
- Within the Children's Therapy Service there was a headcount of 86 staff, comprising 34.84 whole time equivalents (WTEs). The service had a vacancy rate was at 6.88%.

Managing anticipated risks

- In response to anticipated risk to children and young people, the CASH service had developed an outreach programme for young vulnerable adults. This was called the young people's sexual health outreach team (YPSHOT).
- Between April 2013 and March 2014 there had been 153 referrals from multi-agency teams to this service. These referrals came from a variety of services, in both health and social care. The referral criteria for this service took into consideration the growing awareness of child sexual exploitation.
- The YPSHOT team members had specialist skills in supporting and working with young people at risk, and were supported by an advanced nurse specialist post that focused on this area of work. Vulnerability was defined by the young person's age and the reason for the referral.
- We were told that there were resilience plans in place so that a service could be provided in periods of unusually hot weather, or when there was snow or ice on the ground, or other inclement weather. If staff could not get to their clinic base, they could work from the nearest trust facility. Home visits were cancelled or rescheduled. However, specialist four-wheel drive vehicles were not available to take staff to home visits or their place of work during periods of ice and snow.

Major incident awareness and training

- Staff we spoke with were aware of their role in a major incident. The trust's major incident policy was available on the intranet. School nurses and health visitors we talked with told us that they would offer support to the acute care teams within the trust. This would include supporting distressed and anxious families caught up in any major incident, as well as providing cover in wards and clinics.

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

National Institute for Health and Care Excellence (NICE) guidance was followed and audits were undertaken in order to ensure that there was a continuous improvement in service provision.

Overall, we found that staff were supported with training, supervision and appraisal. However, we also found that a number of staff were not satisfied with the systems for group supervision, and that not all staff had received a recent appraisal.

We found that 10,000 records were not completely secure in one of the trust's locations. When we informed the trust managers told us that they would investigate the situation.

We found that there was a well developed system for multidisciplinary and multi-agency working.

Evidence-based care and treatment

- A health visiting community eczema service for pre-school children and their families was provided. This was based on NICE guideline CG57, published in 2007 (Atopic Eczema in Children: Management of atopic eczema in children from birth up to the age of 12 years).
- A health visitor described how they used NICE guideline CG192 (Antenatal and Postnatal Mental Health: Clinical management and service guidance) as part of their practice. They also described the use of the Edinburgh postnatal depression score. They described how, using tools and guidelines as well as their own professional judgement, they would escalate issues of concern.
- General concerns were passed on to the patient's GP, while serious concerns would be immediately escalated to the local mental health crisis team.
- The service provided the "Healthy Child Programme" through teams that consisted of health visitors, school nurses, community staff nurses, nursery nurses, assistant practitioners and health care assistants. The "Healthy Child Programme" is an early intervention and prevention public health programme. It offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices.

Nutrition and Hydration

- We found that the service was fully accredited to the UNICEF (United Nations Children's Fund) "Baby Friendly Initiative Standards". This was confirmed in a letter, dated 2 February 2015, from UNICEF that stated that the service had been accredited as "baby friendly" under the terms of the UNICEF "Baby Friendly Initiative". This initiative is designed to support breastfeeding and parent/ infant relationships by working with public services to improve standards of care.

Approach to monitoring quality and people's outcomes

- A dental neglect questionnaire was being implemented in cooperation with City of York Council, Harrogate and District NHS Foundation Trust, and the City of York Safeguarding Children Board. This was the second audit cycle in this study, which had, in the first audit cycle, found that 60% of children with child protection plans had not seen a dentist in the previous six months. The intention of the audit was to improve access to dental care for children who were the subject of child protection plans.
- In May 2014, the service carried out a random selection review in order to audit how the voice of infants and pre-school children was being captured. This followed recommendations from the paper Working Together to Safeguard Children (HM Government, March 2013). Recommendations from the review included the following, among other things: staff should recognise behaviour as a form of communication; fathers and other significant male family members were to be involved routinely; and staff should continue to use home visits as the safest and most effective method of intervention and support.

Competent staff

- A member of the health visiting team showed us how it was possible for staff to keep up to date with their own training needs through the trust's intranet. The intranet

featured a learning hub that allowed staff to monitor and book their own training, including all the mandatory and statutory training that was required for the performance of their duties.

- Staff were able to undertake developmental training. At the time of the inspection, three band five school nurses were undertaking a specialist community public health course. All developmental training was linked with staff's development plans, which were agreed at their annual appraisals. School nurses and health visitors received Health, Exercise and Nutrition for the Really Young (HENRY) training in child obesity (see www.henry.org.uk).
- We found that a group of community practice teachers was available in order to support the training and practice needs of health visitors and school nurses.
- However, we spoke with five health visitors who told us that their annual appraisals were not up to date. We were also told that appraisals had recently been undertaken on a group basis for health visitors with no one-to-one contact with their managers. We raised this with senior managers for the health visiting service who told us that, although there were group meetings, people's appraisals were always undertaken on a private and confidential one-to-one basis. They also told us that the service was up to date with appraisals, except in the case of staff who had been, or were currently, on long-term sick leave.
- Health visitors and school nurses had a system in which clinical supervision was based on a peer review and a peer meeting process. A senior manager for the service told us that staff had been trained at a local university in order to be able to facilitate these processes. They also told us that if staff wanted to have supervision by a manager or clinical supervisor on an individual basis, this would also be facilitated. However, health visitors and school nurses told us that individual supervision had been refused when this had been requested.
- Newly appointed staff were provided with individual clinical supervision for about the first year in their post as part of their preceptorship. This involved observation of their work which was signed off in their training book.
- We were told by staff that there was a system for safeguarding supervision in place.
- In the case of school nurses, we found that team leaders were supervised and supported by their direct line managers.
- In the CASH service there were programmes for medical students from the Hull York Medical School. There was also a contract with the Yorkshire and the Humber Deanery for training in sexual health for pre-registration house officers (foundation year 1) and senior house officers (foundation year 2).
- We also found that the CASH service offered developmental courses for nursing staff and healthcare assistants (HCAs) based on personal development plans following their annual appraisals. These included courses in screening for HCAs, microscopy, mentorship, NHS Academy courses and foundation degree courses.
- We spoke with two therapists who provided services for children and young people at a clinic in Tadcaster. They told us that they had regular yearly appraisals, with six monthly one-to-one reviews with their manager. They told us that the appraisals looked at their achievements over the previous year, and what their developmental needs were and how these could be linked to available training courses.

Use of equipment and facilities

- While visiting the Park Cottage location, we found about 10,000 school nursing records stored in a room that had not been appropriately secured. There was no lock or alarm system in place. We reported this to a senior manager who told us that a risk assessment had been carried out previously and had found the premises to be secure. They told us that the building itself was locked and had an alarm system in place. However, they also told us that they would organise for the estates department to undertake another security assessment to ensure the records were properly secured.

Multidisciplinary working and coordination of care pathways

- There was evidence of multidisciplinary working with other organisations, including children's social services safeguarding teams and local authority children's centres. Staff in community health services for children, young people and families would refer to children's centres in order for children to get additional support and help. This could include assessments by local authority social services as well as clinical assessments by trust therapists.
- At a children's centre based at the York hospital location we spoke with a physiotherapist who provided postural

management for children referred to them, and to a speech and language therapist who undertook specialist work with children and young people with autistic spectrum conditions.
- There were monthly meetings with social services and other agency partners as part of the local multi-agency risk assessment conference (MARAC).
- There was multidisciplinary working with midwives in the form of joint antenatal clinics at children's centres.
- A new service contract in the CASH service had an increased focus on joint working with GPs.
- The YPSHOT received referrals from, and worked with, agencies such as children's social care, youth services, GPs and paediatricians.

Consent and access to information

- Staff we spoke with told us that they had received training in the Mental Capacity Act 2005 and deprivation of liberty safeguards. They were knowledgeable about the Act and the safeguards.
- We observed health visitors and school nursing staff obtaining verbal consent from people when they were providing care and treatment.
- We found there was a system for obtaining and recording consent from carers and patients, and entering it onto the service's electronic database.
- We found there was good provision of web-based health information for young people. This was provided by www.yor-ok.org.uk. A multidisciplinary information service which the service contributed to.
- The CASH service also provided health information to young people through their www.yorsexualhealth.org.uk website.
- All women who had recently given birth were supplied with breast feeding information, including that supplied by UNICEF (United Nations Children's Fund).

Good

Are services caring?

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

Summary

We found that a caring and compassionate service was provided to children, young people and their families. We also found that people were treated with dignity and respect.

People who used the service told us that they understood the service offered to them and felt that staff involved them in the care offered to them and their family members. However, some people had comments about how they felt the service could be improved.

We also found evidence that the service promoted self-care; and the involvement of patients, carers and parents in the service they received.

Compassionate care

- During our observation of home visits by health visitors we noted warm and compassionate behaviour towards patients and families.
- We also spoke with a family who felt that the care provided was responsive and compassionate.

Dignity and respect

- During our observation of home visits by health visitors we noted that families were treated with dignity and respect. This view was supported by our conversations with families receiving services.

Patient understanding and involvement

- During our observations of home visits, a visit to a hostel for young mothers, and consultations at a children centre, we found appropriate levels of communication employed by the community staff. During home visits, we observed positive interactions between health visitors and mothers.
- A mother we spoke with during a home visit from a health visitor told us that she felt confidence in the health visitor service, which she found very supportive and professional.
- However, a family we spoke with told us that they were not given leaflets in Turkish. We found that facilities for translating leaflets into different languages were available in the trust, although staff had to request this.
- We spoke with a family with a two-year-old child that was generally satisfied with the service. However, they felt that the health visitors concentrated more on the needs of the child. This led to the mother seeking assistance from their GP, assistance that they felt could have been offered by the health visiting team. They also felt that the health visitors lacked knowledge about toxoplasmosis, and they would have expected a greater level of awareness from the team. Toxoplasmosis is an infectious disease caused or transmitted by a parasite, and is therefore a public health issue.
- Young mothers we spoke with at a hostel told us that they were provided with contact details for the health visitors. They told us that they had used the contact numbers provided and that it was easy to get in touch or leave a message. We were told that there was a quick response to messages left.
- There was also evidence that the CASH service had involved young people in improvements to their www.yorsexualhealth.org.uk website. Young people had responded to a survey by saying how they would like the website improved through an easier to use format for tables and a clearer layout for the home page. The service said in their annual report that they were making changes to meet these responses.

Emotional support

- During the home visits we observed staff providing emotional support to patients and their families.

Promotion of self-care

- We found that the service had a well developed system for providing breastfeeding advice to mothers. This was also available in the more deprived areas of York, where evidence had shown that there were low levels of breastfeeding.
- This included “breast feeding supporters”, who were volunteer members of the public, whose contact details were given to all mothers after the birth of their child.

Good

Are services responsive to people's needs?

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

Summary

Services offered to children, young people and families were responsive. This was particularly the case for people who could not communicate in the spoken English language. We found that there were very good systems in place for the provision of translation services for people whose first language was not English, and for sign language interpretation services for people who were profoundly deaf. However, one person told us that they had not been given leaflets in Turkish.

There was also evidence of service planning being developed to meet the needs of different people, especially with regard to the CASH service.

There were systems in place for moving between services.

There was also a system in place for the management of complaints, and staff knew what action to take if they received a complaint.

Service planning and delivery to meet the needs of different people

- The CASH service provided an evening contraceptive clinic in York for young people. An analysis of this service by the trust had found that it was a successful initiative and that an increasing number of young people attended the service.
- The outreach programme for young vulnerable adults run by the CASH service included the provision of education and advice to local schools and colleges.
- The CASH service also ran a programme called YORBABE. This was a five-week course aimed at supporting expectant parents under the age of 19 to prepare for the birth of their baby. The course was tailored to meet the needs of teenage parents who, because of their age and circumstances, may be identified as vulnerable and in need of additional support.

Access to the right care at the right time

- In the CASH contraception services we found that, over the period 2013-14, 73% of people were offered a routine appointment within 48 hours. However, the service found that most people selected an appointment outside this timescale or chose the "walk-in" service.
- Within the report: "Annual report for contraceptive and sexual health services 2013 – 2014 the CASH service reported that there had been a reduction in the number of people offered chlamydia testing, and those taking up the offer, between quarters three and four of 2013/14. This had seen a reduction from 80% to between 76% and 56.9%. The differential figures were the result of disparities between two reporting systems; "Telecare" and "Snapshot". The low percentage of those who took up the offer, at 36.18% was ascribed to people accepting a test elsewhere, not identifying themselves as being at risk, or being reluctant to come forward.
- We also found that the CASH service had developed an outreach programme for young vulnerable adults. The YPSHOT provided an outreach service for children and young people that had a flexible approach to meeting the sexual health needs of vulnerable young people.
- The YPSHOT service showed flexibility in the provision of sexual health services to children and young people.
- We observed care being provided by health visitors and school nurses in people's homes.
- The children's therapies service accepted referral for patients under the age of 18 (or age 19 in education) who were referred by their GP, consultant, or another allied health professional (AHP).
- As well as these services being provided in outpatient clinics or wards; they could be undertaken in the patient's own home, the educational environment or in community children's centres.
- Physiotherapy, occupational therapy services, and speech and language services were provided at four schools in the Scarborough and Ryedale areas.

Meeting the needs of individuals

- We found that young people aged 16 to 19 years were not included in the Healthy Child Programme. This was a result of the way in which the service was commissioned by local authorities and clinical commissioning groups.

Good

Are services responsive to people's needs?

- We found there was no contract with the commissioners of the service for the provision by the trust of a school nursing service outside of term times.
- There was good provision of translation services for people who could not speak English and of professional sign language interpretation for people who were profoundly deaf. These services could be booked by all staff through the trust's intranet and were provided by a nationally recognised organisation that responded in good time to requests.
- Systems were in place that allowed staff to request leaflets and other information to be translated into different languages. A health visitor we spoke with told us that this was a very responsive service as requests could be turned round in about a day. Staff were knowledgeable about the common non-English languages spoken in the area, and mentioned the increasing number of people who spoke Polish. In response to this, advice and information leaflets had been prepared in Polish.
- The service produced advice and information leaflets in braille for people who were registered blind. We also found that a support package produced by the Blind Society of York was used to assist staff in offering services to people with impaired vision.
- The service liaised with child and adolescent mental health services (CAMHS) to provide care for children, young people and families with a learning disability. This took into consideration findings that 50% of service users with learning disabilities were on safeguarding plans.
- 'Service improvement task groups' had been established to examine how services for people with autistic spectrum conditions could best be provided. This included using an 'ages and stages' tool to ensure early recognition and referral, the aim being to identify children with the condition within the first 18 months following birth. To support this, special advice was available for health visitors, and links were in place with an autism charity in York to which parents were referred for further advice and help.
- We found a good provision of breastfeeding support. Through a website which was hosted by the City of York Council, the service provided information to children, young people and families. This included advice to young people on bullying, relationships and sexual health. There was also advice on breastfeeding.
- Innoculations against both influenza and HPV (Human Papilloma Virus) were provided by the service. HPV is linked to cervical cancer.

Discharge, referral and transition arrangements

- Within health visiting there was a protocol for the transfer of babies from maternity to the health visiting teams. This included weekly allocation meetings.
- There were systems, processes and joint meetings for the handover of children's care from the health visiting to the school nursing teams.
- We also spoke with school nurses about the transfer of people's care to adult teams. A team we spoke with in a school location told us that transition arrangements had been poor, although they had recently improved. They said this improvement had included better timescales for referrals to adult social care and for people with a disability. During the transfer, a child passport was used; the service was now putting this onto a CD, for both the transferring young person and their parents.

Complaints handling (for this service) and learning from feedback

- Staff we spoke with were aware of the need to report complaints to their manager in order for them to be investigated through the trust's complaints procedure.
- Health visitors told us that they would leave Friends and Family Test questionnaire cards with patients and families to fill in and then post to the trust. It was possible to complete the card by asking the family questions, but some staff we spoke with felt embarrassed about doing this in front of families and would leave the cards for them to fill in.
- The senior managers responsible for the health visiting and school nursing services told us that there had not been any complaints in the last two years. They said that, although people had complained about the national measurement programme for obesity, this was aimed at a national initiative rather than at the service or the trust.

Good

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

Overall, the service was well led, with evidence of engagement with the public, and people who used the service. This included a patient satisfaction survey of the community eczema service, and the involvement of young people in improvements to a patient information website used by the sexual health service.

However, there was some concern from staff about a lack of support from senior managers within the school nursing and health visiting services. There was concern from staff that monthly team meetings were not always held and that there had not been a meeting of health visitors since December 2014.

We found examples of innovation, improvement and sustainability, although one of the initiatives had not yet been put into practice.

Vision and strategy for this service

- We found that staff we spoke with were aware of the trust's vision.
- Within the CASH service, we found that both the plans for the service and the views of staff agreed on it being an outward-facing and value-driven service that aimed to provide a fully responsive service for children, young people and families.

Governance, risk management and quality measurement

- There were management systems and processes that connected community health services for children, young people and families with the corporate control systems for governance and risk management. There were corporate management reporting mechanisms that flowed from local team managers up to the chief executive and trust board.
- Quality measurement audits were undertaken. For example, a community eczema service audit had looked at, among other things, the benefits of this service being provided by health visitors in the community compared with it being provided by a consultant dermatologist in outpatients, or by GPs. Results indicated that the community eczema service was effective.
- The trust risk register for March 2015 included an entry describing information technology (IT) data issues that had resulted in chlamydia performance data not being collected effectively in the CASH service. This had led to a possible significant loss of income owed to the trust. The review date on the register was July 2015.

Leadership of this service

- Staff we spoke with felt that the chief executive was not very visible and had not visited their clinics or departments on many occasions. We were told this by both health visitors and school nursing staff.
- Although most staff told us that their line managers were visible, we spoke with a number of health visitors who said that this was not the case. We spoke with a group of five school nurses who told us that they had good local leadership from their managers.

Culture within this service

- There were positive elements to the culture of the service, including an openness and willingness to embrace new ideas of working, especially in the CASH service. Staff in the CASH service described "Excellent team working", a supportive environment, and open and honest working relationships. Medical students who spent time in the service provided positive feedback to the deanery.
- However, some staff we spoke with in the health visiting and school nursing teams described a lack of support from senior managers, although this was not the view of all staff within these services.

Public and staff engagement

- Between January and June 2014, the health visiting service undertook a patient satisfaction survey of the community eczema service. This survey included two questionnaires for parents and carers of children: one before they received the service, and another afterwards. Comments were also recorded; these were

generally positive. In one question, people were asked whether they knew enough about their child's eczema. Before receipt of the service, 25 people said that they did not know enough, while nine said that they did know enough about managing their child's eczema. Following receipt of the service, 21 people said that they knew enough about how to manage their child's eczema, while two said that they did not.

- The CASH service undertook service user experience and engagement work, although this was not exclusively related to children, young people or families. This was outlined in the CASH annual report for 2013/14: Annual Report for Contraceptive and Sexual Health Services 2013–2014. It said that all clinics had written feedback mechanisms including trust feedback forms, there was an electronic interactive standpoint for users of the service to feedback on key aspects of the service, and a nurse in charge was available to chat with service users and take informal feedback.
- They had also employed a member of staff on an honorary contract to work on user engagement between September 2013 and March 2014. Responses to the surveys from 25 people indicated that they expected to have 20 minutes for a new, uncomplicated consultation, and 10–20 minutes for a subsequent consultation. Service staff said that they were involved in discussions about how this could be achieved. There were also 45 responses that concerned waiting times, and 17 that concerned the telephone consultation service. With regard to the latter service, 100% of respondents found it acceptable.
- The CASH annual report for 2013/14 described how the use of consultations via telephone or Skype as part of a 'virtual clinic concept' had been discussed with 46 service users and nine other members of the public. Although there was 100% acceptance of the principles of such a service, there were some caveats expressed regarding the reliability of the post for the delivery of test results. This showed that the public was involved in the development of services.
- A leaflet produced by the health visiting service called York Health Visiting: Pregnancy to starting school contained information about the service and also details of how users could contact the service with their views.
- Some health visiting staff told us that they had not had a staff meeting since December 2014. We reviewed the minutes of this meeting, which discussed the training and other work being undertaken to ensure that SystmOne was fully operational for all staff by April 2015. We also reviewed the minutes of a 'team brief' staff meeting for school nurses that took place in February 2015. This meeting was mainly concerned with cascading information from the trust, and school nurses were encouraged to watch a talk given over a video link by the trust chief executive. Both meetings were well attended: there were 20 staff in attendance at each meeting. However, there were 17 apologies for the health visitor meeting, and four apologies for the school nurses' meeting.
- Some health visitors we spoke with felt that there had been no genuine consultation on the 'parent track' programme. They felt that it had been "Presented as a done deal".
- We found that the trust communicated with staff through monthly newsletters that could be viewed on the intranet, including through the learning hub, as well as through emails.
- We found that the work of school nurses at the Park Cottage location had been recognised by them winning a trust star award in 2013.

Innovation, improvement and sustainability

- Breastfeeding initiatives focused on areas of high deprivation had led to an increase in the number of young mothers breastfeeding. In one area, this had led to an increase from no mothers breastfeeding their babies to 10% of mothers doing so.
- The CASH service used a 'sexual exploitation tool book'. This included a pro-forma that was completed for all people under the age of 18 and that took into consideration Gillick competency and Fraser guidelines (see Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security [1984] QB 581).
- In June 2015, the CASH service was due to start an initiative called Operation Liberty that was designed to take young people off the street. This would involve the service working with the police and other agencies.
- The CASH service was in the process of being re-accredited for the national quality award 'You're Welcome' (the Department of Health's quality criteria for young people friendly health services).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2)(c) HSCA (Regulated Activities) Regulations 2014 Good governance. How the regulation was not being met: People who used the service and others were not protected against the inappropriate sharing of patient records as they were not kept securely. This was in breach of Regulation 20(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure that patient records are fully secured when stored, specifically within the school nursing records.